

17671

## CERTIFICATE OF DEATH

17682

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Md.</b>		c. LENGTH OF STAY IN lb <b>Yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>3905 Washington St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3905 Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katharine J. Adams</b>		4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1968</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/1891</b>
9. AGE (In years last birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ulric Hutton</b>		14. MOTHER'S MAIDEN NAME <b>? Janney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-0082</b>	
17. INFORMANT <b>Page Dinnel- Kensington, Maryland</b>		18. ADDRESS <b>3905 Washington St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Croke Myocardial Infarct</b> <b>4120</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>2 hr</b> <b>4 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/16/68</b> , to <b>12/17/68</b> , that (I) (we) last saw the deceased alive on <b>12/16/68</b> , and that death occurred at <b>11</b> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <b>C.H. Ligon MD</b>		22b. DATE SIGNED <b>12/17/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.H. Ligon MD</b>		22d. ADDRESS <b>SUNNY SPRING MD 20860</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/16/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodside Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Brinklow Md.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler 1331 Rockville Pike Rockville, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 17 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film 4-07  
12/20/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17683

1. DECEASED-NAME (Type or Print) <b>GILMORE</b>			First Middle Last <b>AUGUSTA</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>12/7/ 1968</b>			2b. HOUR <b>5 p.m.</b>				
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>July 7, 1919</b>		6. AGE (In years last birthday) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>12 7</b>		IF UNDER 24 HRS. HOURS MIN. <b>15</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery County</b>				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA Montgomery General</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Plumbing</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Norbeck Road</b>	
14. FATHER'S NAME First Middle Last <b>NOAH NMN ADDISON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ALCINDA LOUISA PROCTOR</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT <b>MGH Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound, left chest,</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>with exsanguination</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>981X</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR:AM <b>500 P.M. 12-7 1968</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased shot in left chest by son who used shotgun</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>2815 Norbeck Rd. Silver Spring Montg Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Belden R. Yeap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>DEC. 7, 1968</b>					
EXAMINER'S NAME (Type) <b>BELDEN R. YEAP M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City, town, or county) <b>Silver Spring</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12-11-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ASH MEMORIAL CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring Montg, Md.</b>				
24. FUNERAL DIRECTOR <b>Robert L Snowden Rockville, Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17673

17684

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First Middle Last Clara V. Albright			2a. DATE KNOWN OF DEATH Month Day Year 12 26 19 68			2b. HOUR 77:55 M		
3. SEX F	4. RACE W.	5. DATE OF BIRTH 2-4-63	6. AGE (in years) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 12 26 19 68			2d. HOUR 11:55 A
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 641 Sligo Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Business	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Montgomery S. S.		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 641 Sligo Ave. #201		
14. FATHER'S NAME First Middle Last William Gilbert Kurr			15. MOTHER'S MAIDEN NAME First Middle Last Jenny -- Leonard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) --		17. INFORMANT ADDRESS Leland Albright 641 Sligo Avenue, Sil. Spr. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Dec. 26, 1968		
EXAMINER'S NAME (Type) Belden R. Reap M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-30-1968		23c. NAME OF CEMETERY OR CREMATORY Morningside Cemetery		23d. LOCATION (City or Town) (County) (State) DuBois Deartfield @ Pa.		
24. FUNERAL DIRECTOR J. W. Lee Jr. Warner E. Pumphrey, Inc. 8434 Georgia Avenue				ADDRESS Sil. Spr. Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge

13684

# FOR STATE HEALTH DEPT.

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17672

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17685

1. DECEASED-NAME (Type or Print) <b>Arthur A. F.</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>12</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>7:30</b> M <b>A</b>				
3. SEX <b>Male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>July 25, 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTH-PLACE (State or foreign country) <b>Brooklyn, N.Y.</b>				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San &amp; Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U.S.N. Retired</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgom.</b>		13c. CITY OR TOWN <b>Sil. Spr.</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>8005 Barron St.</b>			
14. FATHER'S NAME <b>Carl F.</b> First Middle Last						15. MOTHER'S MAIDEN NAME <b>Lillian — Anderson</b> First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Navy</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Capt. Carlton F. Agui</b> ADDRESS <b>8005 Barron St. Takoma</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF, <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>Belden R. Read</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>DEC 2, 1968</b>					
EXAMINER'S NAME (Type) <b>BELDEN R. READ, M.D.</b>				ADDRESS (Street, City, Town, or County) <b>254 Barron St. Takoma</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Dec 6-1968</b>					
23b. DATE				23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>				23d. LOCATION (City or Town) (County) (State) <b>Washington Va.</b>					
24. FUNERAL DIRECTOR <b>Arthur Walters</b>				ADDRESS <b>254 Barron St. Takoma</b>				25a. DATE OF REGISTRATION <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First HENRY		Middle T.		Last ALTHEIDE		2. DATE OF DEATH Month Day Year 12 26 1968	
3. SEX male		4. RACE white		5. DATE OF BIRTH 10/10/05		6. AGE (In years last birthday) 63 YRS.		2b. HOUR 12 30 M	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County		Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Engineer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 614 Sligo Ave. Apt. 501	
14. FATHER'S NAME First Middle Last Henry W. Altheide				15. MOTHER'S MAIDEN NAME First Middle Last Bertha Schaum					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no		16b. SOCIAL SECURITY NO. 577-30-2194		17. INFORMANT Address Mrs. Anna L. Altheide (Wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 342 X IMMEDIATE CAUSE (a) <u>Parkinsonism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>350 X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus, Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>68</u> , to <u>12/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>John J. Curry MD</u>		22c. DATE SIGNED 12/26/68		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 9808 Georgetown Ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Linclon Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland.			
24. FUNERAL DIRECTOR <u>Francis Haller</u>		ADDRESS 500 University Blvd W Silver Spring, Md		25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17675										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17687	
1 DECEASED-NAME (Type or print)										First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
SOPHIA S ALVAREZ														Dec 8 Day 1968 Year				8:50 P.M.			
3. SEX		4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR		IF UNDER 24 HRS.					
FEMALE		CAUCASIAN				MAY 5, 1889				79 YRS.				MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.					
XXXXX Ill.				U.S. of AMERICA								MONTGOMERY									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY									
SILVER SPRING				HOLY CROSS HOSPITAL				Housewife				Own Home.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
MARYLAND				MONTGOMERY				SILVER SPRING				YES		3705 WOODBRIDGE AVE.							
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last			
Leonard								Strzelecki		Karseda				xxx				Koseck			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown)				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No								270-03-3073				Mrs. Patricia A. Huguley				5 Woodbridge Ave. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART 1. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>																					
4120 DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
(b) <u>Hypertensive cardiovascular disease</u> 10 years																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
14																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
				HOUR A.M. Month Day Year P.M. 19																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION				Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1968 to Dec. 1968, that (I) (we) last saw the deceased alive on Dec. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE																					
B. L. A. N. E. T. H. E. G.																					
22c. DATE SIGNED																					
Dec 8, 1968																					
22d. PHYSICIAN'S NAME (Type)																					
B. L. A. N. E. T. H. E. G.																					
22e. ADDRESS																					
9801 Daisy in Oakwood Springs, Md.																					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial				Dec. 12, 1968				Holy Cross Cemetery				Calumet City, Illinois									
24. FUNERAL DIRECTOR				24a. ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Warner E. Pumphrey, Inc.				C. Glen Carter 843 Georgia Avenue Silver Spring, Md.				DATE				DEC 12 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17677						17688					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
HELEN F. Amiss						Dec 25 1968			7 PM		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER YEAR		8. UNDER 24 HRS	
FEMALE		WHITE		12-7-89		79 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		US.				Montgomery					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
BETHESDA				SUBURBAN				Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE				13b. CITY OR TOWN		13c. INS DE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md. Montgomery				Bethesda				4860 Chevy Chase Blvd.			
14. FATHER'S NAME				15. MOTHER'S MARDEN NAME							
John Farish				Lelia Holloway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No						Helen C. Badger					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive failure											
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 68, to Dec 25 19 68, that (I) (we) saw the deceased alive on 12/24 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Marvin Wadler						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/25/68			
22d. PHYSICIAN'S NAME (Type) MARVIN WADLER						22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		12-28-68		Forest Oak Cemetery				Gaithersburg, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			





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17678		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17689	
CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or print) First Middle Last <i>John A. Anderson</i>			2a. DATE OF DEATH Month Day Year <i>Dec. 31, 1968</i>		2b. HOUR Minute <i>7:15</i>
3. SEX <i>male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>Aug. 7, 1901</i>		6 AGE (Last birthday) <i>67</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		Md.			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Vice-president</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Safeway</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md. Mont. Co.</i>		13b. CITY OR TOWN <i>Cherry Chase</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <i>3604 Dunlap St.</i>	
14 FATHER'S NAME First Middle Last <i>James Theodore Anderson</i>		5. MOTHER'S MAIDEN NAME First Middle Last <i>Hedella Liggett</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give unit or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577-05-1566</i>		17 INFORMANT Name Address <i>E. Hall Anderson 5130 Wisc. Ave. NW Wash. D.C.</i>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))					
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>					
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery pt. disease</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
4129					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , 19, to <i>12/31</i> , 19 <i>68</i> ; that (I) (we) last saw the deceased alive on <i>12/31/68</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Bernard J. Walsh</i>		22c. DATE SIGNED <i>1/1/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>BERNARD J. WALSH</i>		22e. ADDRESS <i>1800 EYE ST NW WASH. DC</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>Jan 4, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	
23d. LOCATION (City or Town) (County) (State) <i>Suitland Md.</i>					
24. FUNERAL DIRECTOR <i>Jos. Gawler Sons</i>		ADDRESS <i>5130 Wisc Ave NW Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>JAN 8 1969</i>	
25b. REGISTRAR'S SIGNATURE <i>John A. Walsh</i>					



17679

## CERTIFICATE OF DEATH

17690  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>9206 North Avenue</u>				d. STREET ADDRESS <u>9206 WORTH AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>OLIVE</u> First <u>FRANCES</u> Middle <u>ANKERS</u> Last				4. DATE OF DEATH Month <u>DEC</u> Day <u>3</u> Year <u>1968</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 APR 1890</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>AMIBADSE BLADEN</u>				14. MOTHER'S MAIDEN NAME <u>MARIA EANT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>DAUGHTER 9206 WORTH AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>							
4339 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CEREBRAL ARTERIO SCLEROSIS</u>							
DUE TO (c) <u>ARTERIO SCLEROSIS GENERALIZED</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>27 NOV</u> , 19 <u>68</u> , to <u>3 DEC</u> , 19 <u>68</u> , that I last saw the deceased alive on <u>2 DEC</u> , 19 <u>68</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas P. Fogarty</u>				ADDRESS (Street, city or town, state) <u>820 UNIVERSITY BLVD E. SILVER SPRING, MD.</u>			
DATE SIGNED <u>3 Dec 68</u>							
PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>REMOVAL-BURIAL</u>		<u>12/3/68</u>		<u>Chestnut GROVE</u>		<u>HERNDON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Berkeley Green, Herndon, Va.</u>				ADDRESS		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
						DATE <u>DEC 13 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician's office and completely filled in by the funeral director, and completely filled in by the funeral director. After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

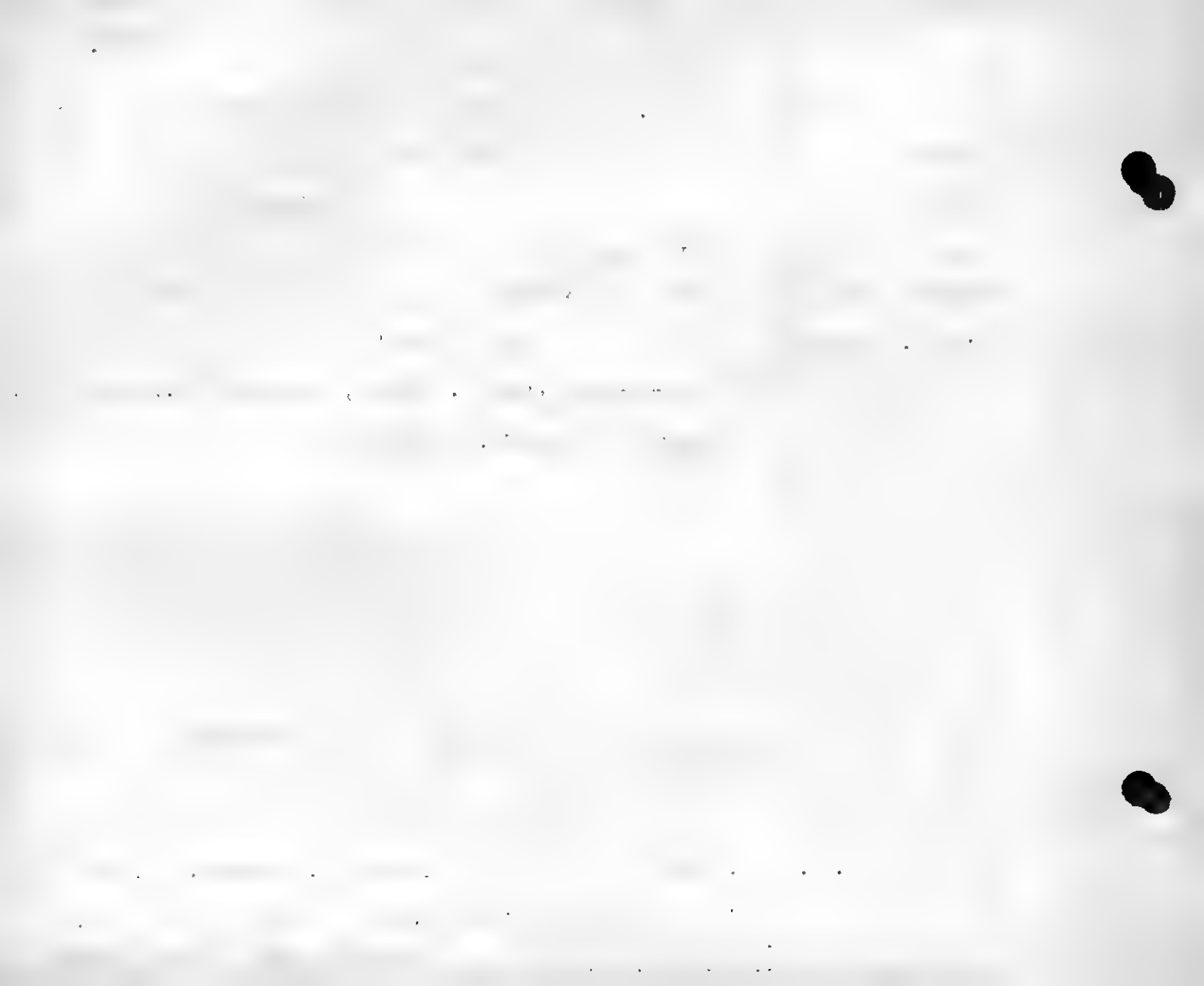


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17650										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17691									
CERTIFICATE OF DEATH																													
1 DECEASED-NAME (Type or print)					First Middle Last					2a DATE OF DEATH					2b HOUR														
Alice					L. ASHWELL					22 December 1968					8:10A M														
3 SEX					4. RACE					5 DATE OF BIRTH					6. AGE (In years last birthday)					7 UNDER 1 YEAR					IF UNDER 24 HRS.				
Female					Cauc					1 Sep 1921					47 YRS.					MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Wisconsin					USA										Montgomery					Md									
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY ***														
Bethesda					Naval Hospital					Housewife																			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INS DE CITY LHM TSP					13e STREET AND NUMBER									
Bethesda, Maryland					Montgomery					Bethesda					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					929 Bardon Road									
14 FATHER'S NAME					First Middle Last					15 MOTHER'S MAIDEN NAME					First Middle Last														
Paul L. ISBERNER										Myrtle McNICOL																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO					17 INFORMANT					Address														
NO					322-24-9391					James T. ASHWELL, 929 Bardon Rd., Bethesda, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia, Left Upper Lobe</u>																													
485 X DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) <u>storing the underlying cause last.</u>																													
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																													
(c) _____																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
441 X																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (A) (this hospital) attended the deceased from <u>December 14, 1968</u> to <u>December 19, 1968</u> , that <u>xx</u> (we) last saw the deceased alive on <u>22 December</u> , 19 <u>68</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>xx</u> (we) (did) <u>not</u> view the body after death.																													
22b. SIGNATURE															DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED				
																									12/23/68				
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
S. F. DOVI, LCDR MC USN															Naval Hospital, Bethesda, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12/24/68					Arlington National Cemetery					Arlington Va.														
24. FUNERAL DIRECTOR															25a. REC'D BY REG STRAR					25b. REG STRAR'S SIGNATURE									
Robert A. Pumphrey Funeral Home															DATE					JAN 2 1969									
7557 Wisconsin Ave., Bethesda, Md.																									Charles Judge				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17681		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17692	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) <b>Claude B. Ashwell</b>			2a. DATE OF DEATH Month <b>12</b> - Day <b>26</b> - Year <b>1968</b>			2b. HOUR <b>5:20</b> M	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-23-1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY Co - Md.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Springs Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bella Vista Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Shoemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>store</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>Takoma Pk</b>		13d. INSIDE CITY LIM TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Daniel</b> Middle <b>--</b> Last <b>Ashwell</b>		15. MOTHER'S MAIDEN NAME First <b>Dora</b> Middle <b>M.</b> Last <b>Witt</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war and dates of service) <b>--</b>			
16b. SOCIAL SECURITY NO. <b>577-05-2265 A</b>		17. INFORMANT Address <b>Jak. Park, Md.</b> <b>Sicily Ashwell 7908 Kennewick Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>412.1</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>57.2</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 Hrs</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> , 19 <b>68</b> , to <b>12/26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold Heiges M.D.</b> DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>12/26/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>HAROLD HEIGES</b>				22e. ADDRESS <b>5415 Conn. Ave NW Wash DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-30-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pr. Geos. Md.</b>	
24. FUNERAL DIRECTOR <b>J. W. Lerner</b> <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>				25a. REG. BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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1

17692

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17693

1. DECEASED NAME (Type or print) <i>Ruth</i>			First <i>P</i> Middle <i>A</i> Last <i>Atwood</i>			2a. DATE OF DEATH Month <i>Dec.</i> Day <i>11</i> Year <i>1968</i>			2b. HOUR <i>7:30 AM</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>8-14-1895</i>			6. AGE (In years last birthday) <i>73</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Kensington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>11025 Madison Street</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Clerk - V.A.</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montg.</i>			13c. CITY OR TOWN <i>Kensington</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>11025 Madison St.</i>			14. FATHER'S NAME First <i>William</i> Middle <i>O.</i> Last <i>Parsley</i>			15. MOTHER'S MAIDEN NAME First <i>Christina</i> Middle <i>--</i> Last <i>Mulligan</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>214-03-8069</i>			17. INFORMANT <i>John Atwood</i>			Address <i>Maryland</i> <i>11025 Madison Street, Kensington</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction, acute</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i> <i>15 hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>42</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1952, to <i>Dec 11</i> , 1968, that (I) (we) last saw the deceased alive on <i>12/2</i> , 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A.D. Bonifant</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>12/11/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>A.D. BONIFANT</i>						22e. ADDRESS <i>Sandy Springs, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12-14-1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Montg. Md.</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>						25a. REC'D BY REGISTRAR <i>DEC 16 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		





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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

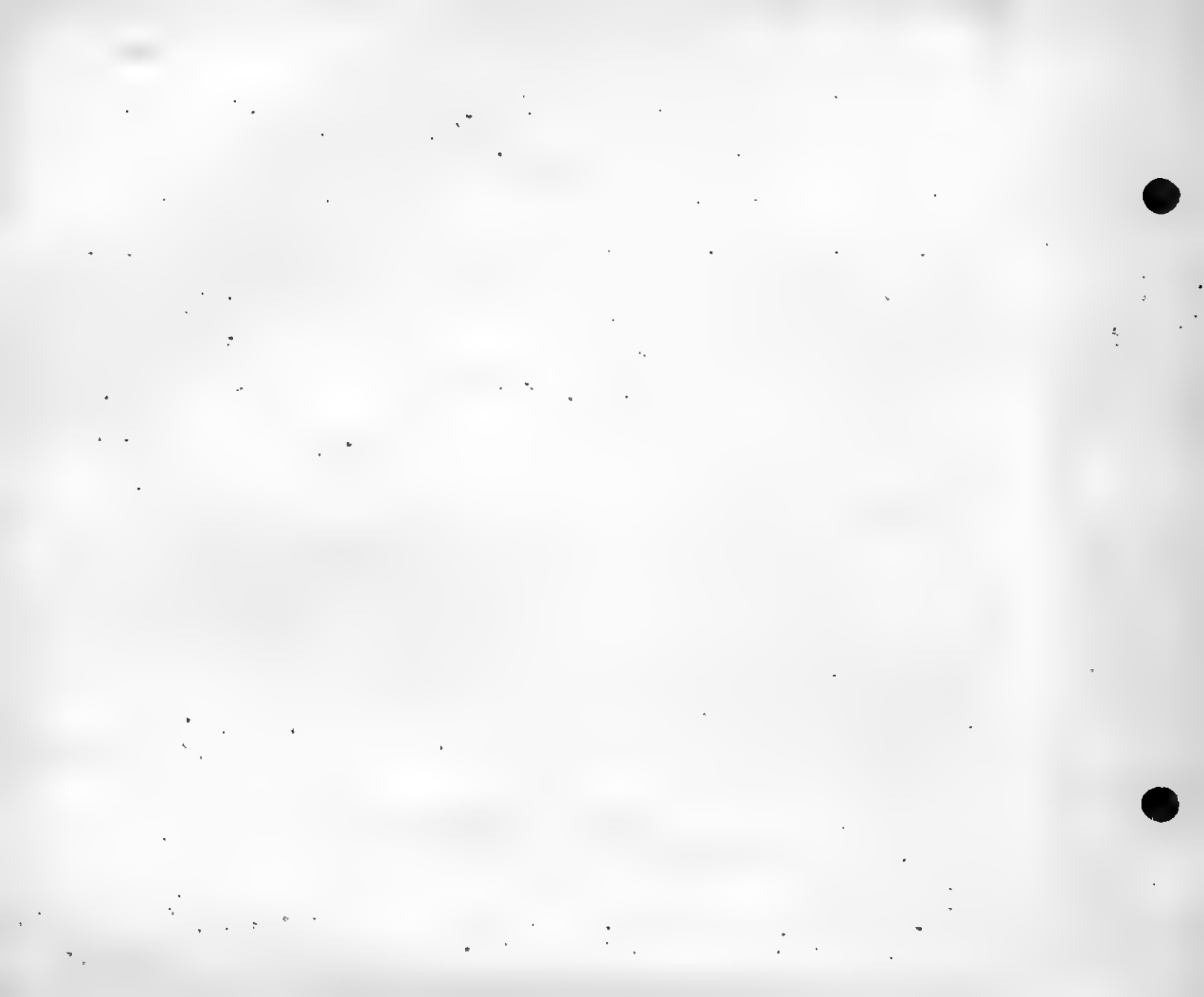
CERTIFICATE OF DEATH

17693

17694

1. DECEASED NAME (Type or print) <b>Robert H Bailey</b>			2a. DATE OF DEATH Month <b>Dec</b> Day <b>14</b> Year <b>68</b>			2b. HOUR <b>6:30</b> M	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>1 Oct. 1909</b>		6. AGE (In years lost birthday) <b>59</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rock Cross Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Union</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>J</b> Middle <b>D</b> Last <b>Bailey</b>		15. MOTHER'S MAIDEN NAME First <b>JANE</b> Middle <b>Magwood</b> Last <b>Magwood</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>414-24-986</b>	
17. INFORMANT <b>Mary Carter</b>		Address <b>2 Lincoln Lane GOLFORD MISS.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis of Liver</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street, or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <b>12/11/68</b> , to <b>12/14/68</b> , that (I) (we) last saw the deceased alive on <b>12/14/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <b>John J. Curry</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/15/68</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. REC'D BY REGISTRAR <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec 19 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sargentsville Town</b>		23d. LOCATION (City or Town) (County) (State) <b>Sargentsville Tenn.</b>	
24. FUNERAL DIRECTOR <b>Walter H. H. H.</b>		ADDRESS <b>254 Carroll St. Washington D.C.</b>		DATE <b>DEC 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 14,  
45M - 1/69

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Charles Bang					Month	Day	Year	9:30 M	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white		11/8/01		67 YRS		11	2	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
N. J.	U. S. A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Suburban Construction			Private			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Md			Montgomery Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5807 Wengate Drive			
14. FATHER'S NAME			15. MOTHER'S M A D E N NAME						
First Middle Last			First Middle Last						
David Bang			Andrea Beck						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
yes			224-16-6000		Wife Margaret Bang Address same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, recent & remote, left ventricle (posterior) & septum									
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Severe coronary arteriosclerosis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1465, 1968, to 12/10/1968, that (I) (we) lost saw the deceased alive on 12/10/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS.		22c. DATE SIGNED
W.T. Joyce							MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
W.T. Joyce					4477 Battery La Mont Md				
23a. BURIAL CREMATION			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial XXX			12-14-68		Mount Greenwood		WORTH Cook Ill.		
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
7557-Wisconsin Ave., Bethesda, Md.					DATE DEC 16 1968		Charles Judge		



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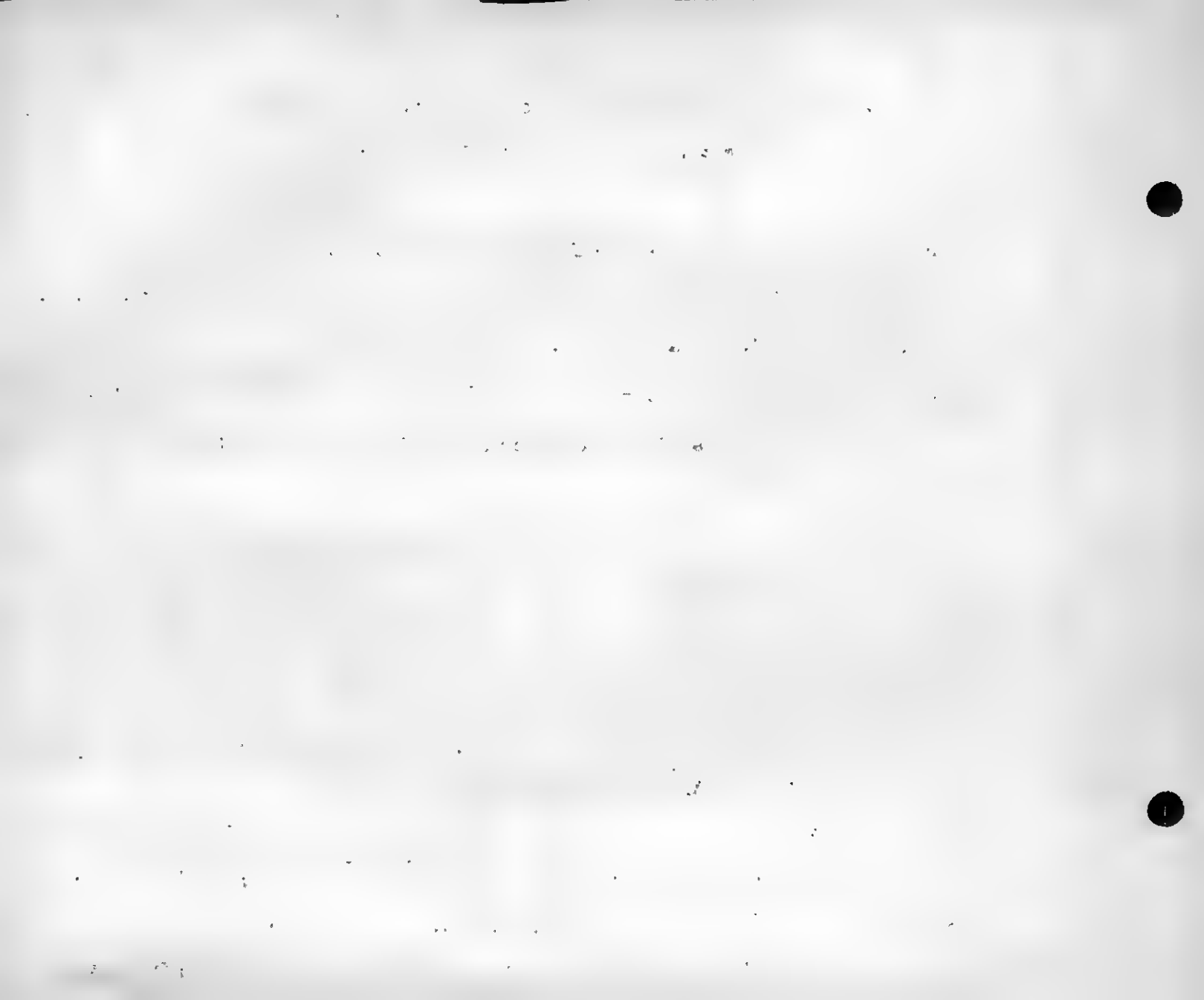
17685

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17696

1. DECEASED-NAME (Type or print) <b>Charles Curtis Barbour, Jr.</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>10:40</b> AM	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>26 January 1928</b>		6. AGE (in years last birthday) <b>40</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of work on date, even if retired) <b>Street Cleaner</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Virginia</b> COUNTY <b>Roanoke</b>		13c. CITY OR TOWN <b>Roanoke</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1302 Hanover Ave., N. W.</b>	
14. FATHER'S NAME First Middle Last <b>Charles C. Barbour, Sr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Madeline Woods</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>1953-1955</b>		16b. SOCIAL SECURITY NO <b>222-30-7277</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, NIH, Bethesda, Md. 20014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas, with widespread metastasis</b> 6 Months <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1579</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7 Nov.</b> , 19 <b>68</b> , to <b>29 Dec.</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>29 Dec.</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Michael B. Mosher</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>29 December 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Michael B. Mosher, MD.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Williams Mem. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Roanoke, Virginia</b>	
24. FUNERAL DIRECTOR <b>Fraziers Funeral Home, Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17686

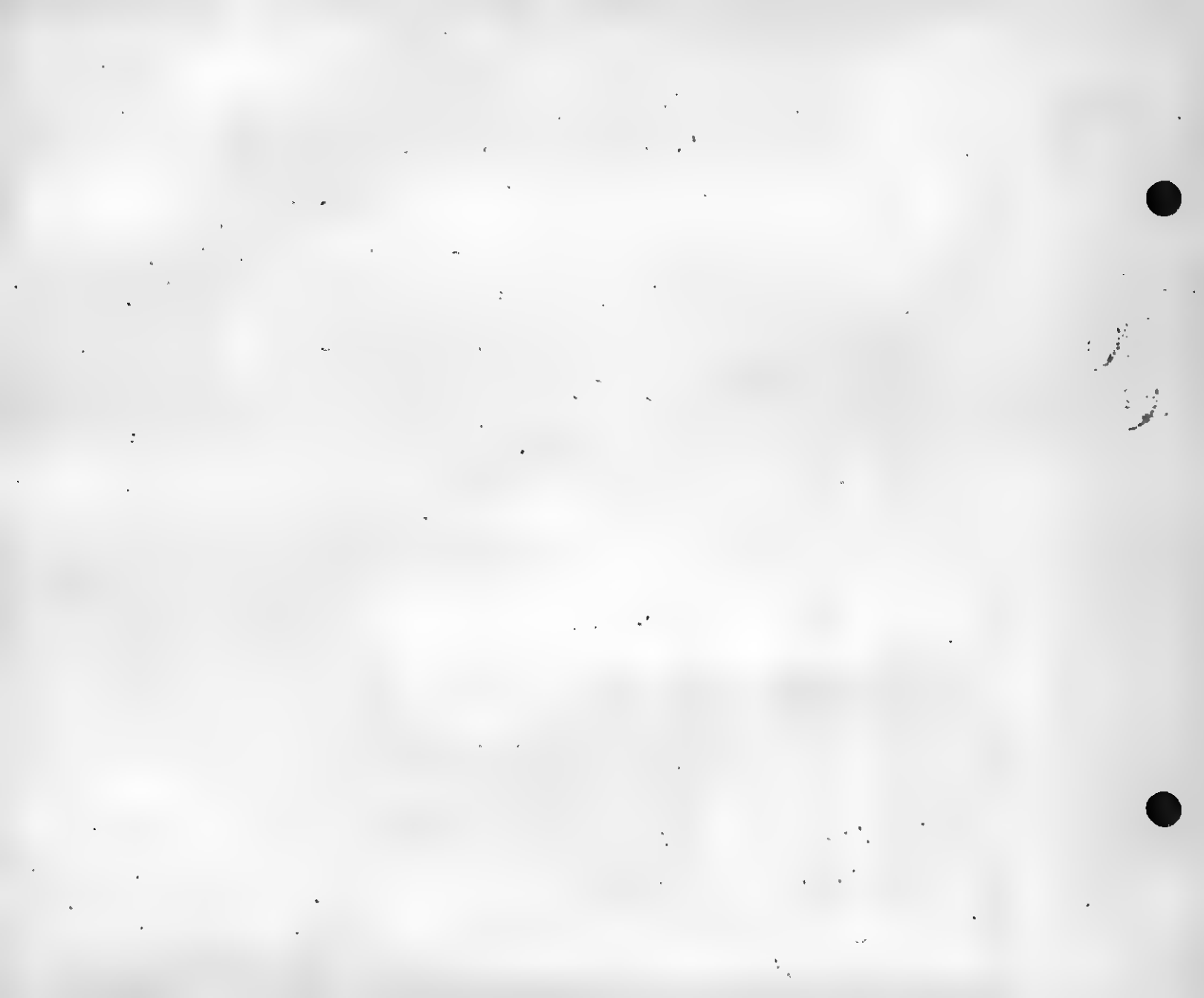
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17697

1 DECEASED NAME (Type or print) <b>Dirk Petrus Bart</b>			2a DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>68</b>			2b HOUR <b>1:50 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>7-20-97</b>		6 AGE (in years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Holland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Restaurant Opn.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE - <b>Virginia</b>		13b. COUNTY <b>Fairfax</b>		13c CITY OR TOWN <b>Alexandria</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5420 North Morgan Street</b>	
14. FATHER'S NAME First <b>Dirk</b> Middle <b>Bart</b> Last <b>Schuit</b>			15 MOTHER'S MAIDEN NAME First <b>Dina</b> Middle <b>Schuit</b> Last <b>Schuit</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16b SOCIAL SECURITY NO <b>577-56-2283</b>		17. INFORMANT <b>Wash. San Records</b>		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Liver Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Melenoma, primary</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>6 mos.??</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>11</b>									
19a. DATE OF OPERATION <b>Nov 21, 1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma-Melanoma of Liver</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 7</b> , 19 <b>68</b> , to <b>Dec 11</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Dec 11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>W. W. Eastman</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>12-11-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>W. W. Eastman, M.D.</b>				22e ADDRESS <b>831 University Blvd E. Silver Spring Md</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b DATE <b>12/14/1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cathary</b>		23d LOCATION (City or Town) (County) (State) <b>Fairfax Co. Va.</b>			
24. FUNERAL DIRECTOR <b>Murphy Fun. Home</b>				ADDRESS <b>ARLINGTON, Va.</b>		25. REC'D BY REGISTRAR <b>DEC 17 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Nellie E. Beall</i>			2a. DATE OF DEATH Month <i>Dec.</i> Day <i>27</i> Year <i>1968</i>			2b. HOUR <i>9:30</i> P.M.					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11/16/84</i>		6. AGE (In years last birthday) <i>74</i> YRS.		7. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		8. OVER 24 HRS HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Blacksburg</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Home</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>105-Luckett Street</i>			
14. FATHER'S NAME First <i>James P.</i> Middle <i></i> Last <i>Beall</i>		15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Ragun</i> Last <i></i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-42-1729</i>		17. INFORMANT <i>Leonard Beall</i> Address <i>Blacksburg, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Mesenteric Vascular Insufficiency</i>										<i>Hours</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Rheumatic Endocarditis</i>										<i>Years</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>										<i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diverterculitis of Large Intestine</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i></i> Day <i></i> Year <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No <i></i> City or Town <i></i> County <i></i> State <i></i>							
22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Dec 18</i> , 19 <i>68</i> , to <i>Dec 27</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Dec 27</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <i>Harris M. Kenner M.D.</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/28/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Harris M. Kenner M.D.</i>				22e. ADDRESS <i>5411 Cedar Lane Bethesda Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/30/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg. Md.</i>					
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>				ADDRESS <i>1331 Rockville Pike</i>		25a. REC'D BY REGISTRAR <i>JAN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## CERTIFICATE OF DEATH

17698

17699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <i>William Thomas Beall</i>		2a. DATE OF DEATH Month <i>12</i> Day <i>8</i> Year <i>68</i>		2b. HOUR <i>7:45</i> M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>August 27, 1885</i>		6. AGE (In years lost birthday) <i>83</i> YRS
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>622 Hobbs Drive</i>		9. COUNTY OF DEATH <i>Montgomery</i> Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Sil. Spr.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <i>George</i> Middle <i>W.</i> Last <i>Beall</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>E.</i> Last <i>Wilson</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>--</i>		16b. SOCIAL SECURITY NO. <i>214-03-8698</i>		17. INFORMANT Address <i>Maryland</i> <i>E. Caroline Beall 622 Hobbs Drive, Sil. Spr.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of prostate</i> DUE TO, OR AS A CONSEQUENCE OF <i>metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>64</i> , to <i>Dec 8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Dec 4</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Bernard A. Fitzgerald M.D.</i>		22c. DATE SIGNED <i>12-8-68</i>		22d. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>
22e. ADDRESS <i>217 UNIV. BLVD E, SILVER SPRING, Md</i>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-11-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>
23d. LOCATION (City or Town) <i>Adelphi</i>		23e. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>		23f. REGISTRAR'S SIGNATURE <i>Phyllis Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
45M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Alva F. Beane</i>						2a DATE OF DEATH <i>12</i> Month <i>25</i> Day <i>68</i> Year			2b HOUR <i>1:30</i> P.M.		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>4-9-94</i>		6 AGE (in years last birthday) <i>74</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Winery Store</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Self-Employed</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Mont.</i>			13c CITY OR TOWN <i>Rockville</i>			13d INS DE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER <i>129 S. Adams St.</i>			14 FATHER'S NAME First <i>William E.</i> Middle <i>Beane</i> Last <i>Beane</i>			15 MOTHER'S MAIDEN NAME First <i>Ada</i> Middle <i>Burr's</i> Last <i>Burr's</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (fill in) or Unknown ( ) (If yes give war or dates of service) <i>No</i>			16b SOCIAL SECURITY NO <i>216-32-1337A</i>			17 INFORMANT <i>Bessie B. Beane</i>			Address <i>129 S. Adams, Rockville Md</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myelocytic Leukemia</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>1 mo.</i>											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) <i>2</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>20% Azotemia &amp; Acidosis</i>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <i>Dec 23, 1968</i> to <i>Dec 25, 1968</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Dec 25, 1968</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death											
22b SIGNATURE <i>James W. Egan M.D.</i>			22c DATE SIGNED <i>12.25.68</i>			22e ADDRESS <i>5413 Cedar Lane - Bethesda Md</i>			22f REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
23a BURIAL CREMATION <i>XXXXXX</i>			23b DATE <i>12-28-68</i>			23c NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Rockville, Montgomery, Md.</i>		
24 FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>			ADDRESS <i>Bethesda, Md.</i>			25a REC'D BY REGISTRAR <i>JAN 2 1969</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6210-WEDGEWOOD RD.</u>		d. STREET ADDRESS <u>6210-WEDGEWOOD RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>Beckley</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1968</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1909</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOSEPH BECKLEY</u>	
14. MOTHER'S MAIDEN NAME <u>ELLEN GALLAGHER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Evelyn Beckley - 2 D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Congestive Heart Disease</u> DUE TO (c) <u>Arterio-sclerotic heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 yrs.</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>42</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 1958, to <u>Dec.</u> , 1968, that (I) (we) last saw the deceased alive on <u>4 December 1968</u> , and that death occurred at <u>3 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis X. Richardson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson, M.D.</u>		22d. ADDRESS <u>11412 Veirs Mill Road Wheaton, Maryland 20902</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/23/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (City, town or county) (State) <u>SILVER SP. MD.</u>
24. FUNERAL DIRECTOR <u>HANLON FUNERAL HOME WASHA</u>		25a. REC'D BY REGISTRAR <u>JAN 2 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2a 11mG407 12/12/68 Kc MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17691 CERTIFICATE OF DEATH 17702									
1 DECEASED NAME (Type or print) <u>Charles A Bennett</u>					2a. DATE OF DEATH <u>Dec. 13, 1968</u>				
3 SEX <u>M.</u> 4 RACE <u>White</u> 5 DATE OF BIRTH <u>6/21/90</u>					6 AGE (in years last birthday) <u>78</u>				
7a BIRTHPLACE (State or foreign country) <u>Penna.</u>					7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <u>Montgomery</u>				
10 CITY OR TOWN OF DEATH <u>Bethesda</u>					11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u>				
12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <u>Clergeman</u>					12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u>					13b. CITY OR TOWN <u>Bethesda</u>				
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13d. STREET AND NUMBER <u>5505 Warner St.</u>				
14 FATHER'S NAME First <u>George D</u> Middle <u>Bennett</u> Last <u>Bennett</u>					15. MOTHER'S MAIDEN NAME First <u>Alice</u> Middle <u>-</u> Last <u>-</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No.</u> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <u>520 40 6996 A</u>				
17. INFORMANT <u>Wera L. Bennett</u> (wife) Address <u>Same as above</u>									
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1968</u> , to <u>Dec 4, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d-d) (did not) view the body after death.									
22b. SIGNATURE <u>Robert H. Coale</u>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>Dec. 4, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>ROBERT N COALE</u>			22e. ADDRESS <u>4429 Bradley Lane Chevy Chase, Ind.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE <u>12-6-1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u>			
23d. LOCATION (City or Town) <u>Cheyenne, Wyoming</u>			23e. LOCATION (County) <u>Wyoming</u>			23f. LOCATION (State) <u>Wyoming</u>			
24. FUNERAL DIRECTOR <u>Joe. Gumbert Sons</u>			ADDRESS <u>5130 Wisconsin Ave</u>			25. REC'D BY REGISTRAR <u>DEC 9 1968</u>			
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1822a Form 4-69 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3/5/59 17703									
1 DECEASED-NAME (Type or Print) <u>Christine Marie Bennett</u>						2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 12/27/68 160 6:50M		2b HOUR	
3 SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH <u>12-21-18</u>	6 AGE (In years last birthday) <u>50</u> YRS	IF UNDER 1 YEAR MONTHS <u>6</u> DAYS <u>6</u>	IF UNDER 24 HRS HOURS <u>6</u> MIN.	2c. DATE PRONOUNCED DEAD Month <u>12</u> Day <u>27</u> Year <u>1968</u>		2d HOUR	
7a BIRTHPLACE (State or foreign country) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>		Md	
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Montgomery</u> COUNTY <u>Montgomery</u>		13b CITY OR TOWN <u>Silver Spring</u>		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <u>607 Warline Dr</u>			
14. FATHER'S NAME First <u>William</u> Middle <u>James</u> Last <u>Bennett</u>			15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>Ann</u> Last <u>Bennett</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute hemorrhagic viral pneumonitis</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>47d-x</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year <u>12</u> <u>27</u> <u>1968</u> HOUR A.M. <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No <u>607 Warline Dr</u> City or Town <u>Silver Spring</u> County <u>Montgomery</u> State <u>Md</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden R. Reap</u>		EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <u>DEC. 27, 1968</u>			
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Cremation</u>		23b. DATE <u>1-13-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington San &amp; Hospital</u>		23d. LOCATION (City or Town) <u>Takoma Park</u> (County) <u>Mont.</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR <u>J.D. Ruffcorn</u>				ADDRESS <u>7600 Carroll Ave., Tk Pk, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form CMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17704	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <u>WILLIAM BRUCE BENSON</u>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <u>Dec 14 1968</u>			2b. HOUR <u>9:15 AM</u>					
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>APRIL 11 1906</u>		6. AGE <u>62</u> years (last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>MONTGOMERY</u>		
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SUBURBAN</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Manly Co. Employee</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Reads</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MARYLAND</u>			13b. COUNTY <u>MONTGOMERY</u>			13c. CITY OR TOWN <u>ROCKVILLE</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <u>1208 HIGHWOOD ROAD</u>			14. FATHER'S NAME First Middle Last <u>William H. Benson</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Nettie E. Grimes</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		
16b. SOCIAL SECURITY NO <u>577-46-7747</u>			17. INFORMANT <u>Alice Ennis - Arlington Va.</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Nephritis</u>										<u>6 Weeks</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia from Decubitus Ulcers</u>										<u>Weeks</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hip Fracture</u>										<u>4 Months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4040 Cardio Vascular Disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <u>NOON PM Aug 17 1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fell at Home causing Fracture of Hip</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) <u>Home</u>			21f. LOCATION Street or RFD No City or Town County State <u>1208 Highwood Rd. Rockville Montgomery Md.</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John S. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>Dec. 14, 1968</u>		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>12/17/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>			23d. LOCATION (City or Town) (County) (State) <u>Beallsville Montg. Md.</u>		
24. FUNERAL DIRECTOR <u>W.C. Kelt, Barnesville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>DEC 18 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Frances Annette BIRKETT						Dec. 20 1968		11:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Female		Caucasian		Jan. 24, 1918		30 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Montgomery		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Florida			Monroe		KEYWEST		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2506 Linda Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William Rodney English			Ada Bell KENNERLY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> no			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
			215-05-1960		Hospital records, Naval Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <del>HEPATIC</del> PNEUMONIA, BILATERAL, BRONCHIAL										
485X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
411X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from November 15 1968 to December 20 1968, that (X) (we) last saw the deceased alive on December 20 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			12/22/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
D. R. FOREMAN					Naval Hospital, Bethesda, Md.					
23a. MANNER OF BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town, county, state)				
Burial		12/22/68		Southern Keys Cemetery		Key West, Florida				
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.					DEC 26 1968					





17605

## AGNES CERTIFICATE OF DEATH

17706

1. DECEASED-NAME (Type or print) <i>Catherine</i>			First Middle Last <i>Bliss</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>9</i> Year <i>68</i>			2b. HOUR <i>7:10 P.M.</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>6-27-83</i>			6. AGE (In years last birthday) <i>85</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Senior Hosp.</i>			12a. JSOA. OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Pr. Geo.</i>			13c. CITY OR TOWN <i>Hyattsville</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>5801 42nd Ave.</i>			14. FATHER'S NAME First <i>Patrick</i> Middle <i>Flannery</i> Last <i>Ellen</i>			15. MOTHER'S MAIDEN NAME First <i>Kelly</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <i>unknown</i>			17. INFORMANT <i>Hosp. Records</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>485X</i> IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>491X</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Two days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Polyt. Parkinson's Disease Arteriosclerosis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>August</i> , 1967, to <i>December 9</i> , 1968, that (I) (we) lost the deceased alive on <i>December 9</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stuart Nelson</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>12-10-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>STUART. NELSON</i>			22e. ADDRESS <i>Univ. Blvd. E. Silver Spring Md</i>								
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Buried</i>			23b. DATE <i>Dec 12 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington 20C</i>		
24. FUNERAL DIRECTOR <i>Stakoma</i>			25a. REC'D BY REG. STRAR <i>Charles Judge</i>			25b. REG. STRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATE ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

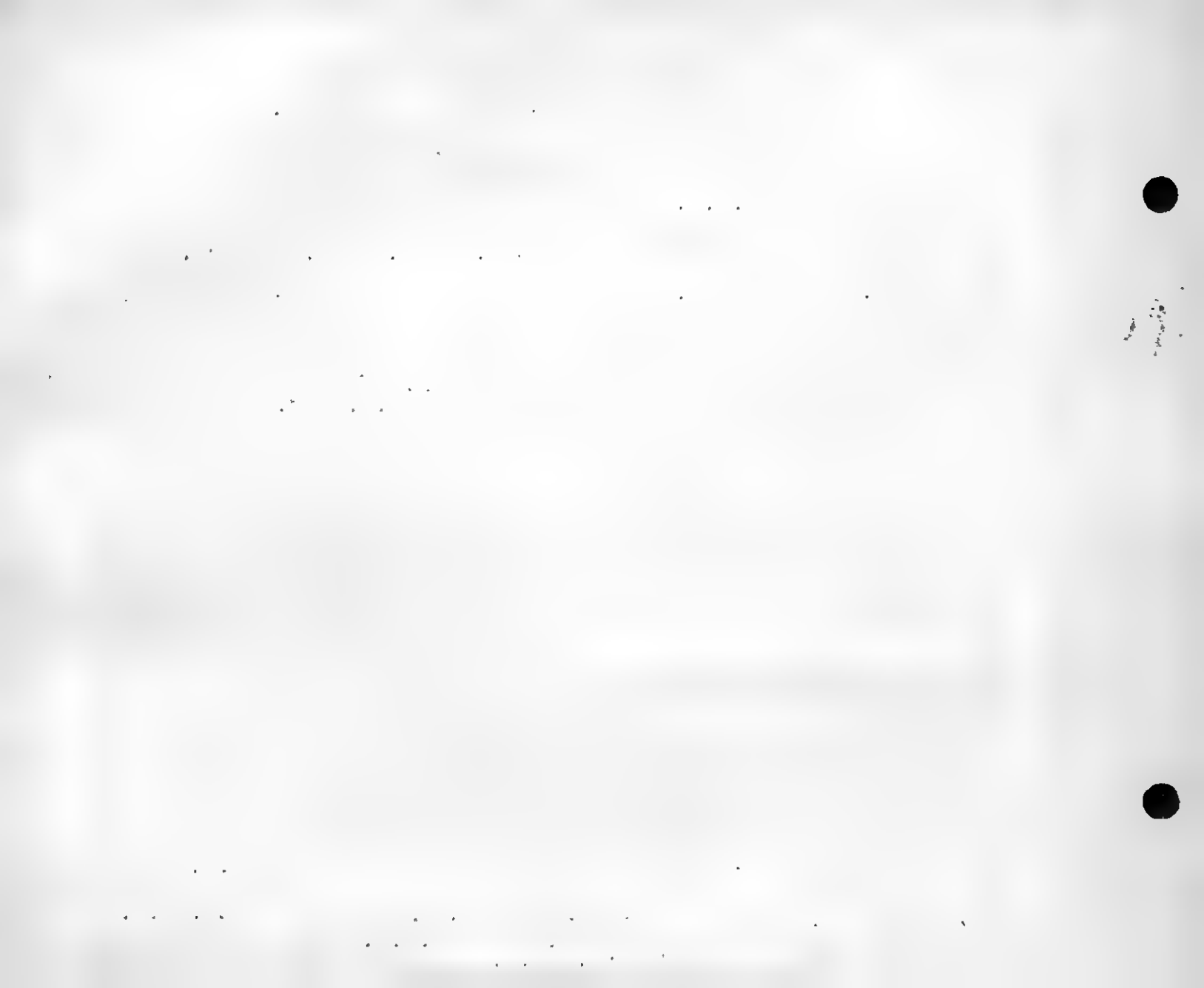
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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17696										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17707	
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR	
First Middle Last HARRY BLUM										Month Day Year Dec. 11 1968										2:15 PM	
3 SEX M			4. RACE White			5. DATE OF BIRTH Sept. 12, 1899			6. AGE (In years last birthday) 69 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF 1 YEAR OR OVER HOURS MIN.						
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md												
7c BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md												
10. CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Auto-Mechanic Musician			12b KIND OF BUSINESS OR INDUSTRY												
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Mont.			13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? NO <input type="checkbox"/> YES <input type="checkbox"/>			13e STREET AND NUMBER 1131 University Blvd W									
14 FATHER'S NAME First Middle Last David Blum					15 MOTHER'S MAIDEN NAME First Middle Last Sophie Piepert																
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO					17 INFORMANT Address Anne Blum, Wife, 1131 University Blvd. W											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY																					
IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>																					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u>															12 yrs						
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County			State						
22a. I certify that (I) (this hospital) attended the deceased from <u>9/9/57</u> 19 <u>57</u> , to <u>12/11/68</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>10/15/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Bernard J. Walsh MD</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED 12/11/68						
22d. PHYSICIAN'S NAME (Type) BERNARD J. WALSH MD															22e. ADDRESS 1800 Eye Street, N.W.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/12/68			23c. NAME OF CEMETERY OR CREMATORY Adas Israel Con. Cem			23d. LOCATION (City or Town) (County) (State) Wash., D.C.												
24. FUNERAL DIRECTOR Bernard Danzansky & Sons																					
ADDRESS 8501 14th St. N.W. REGISTRAR Wash., D.C. DEC 16 1968 REGISTRAR'S SIGNATURE <u>Charles Judge</u>																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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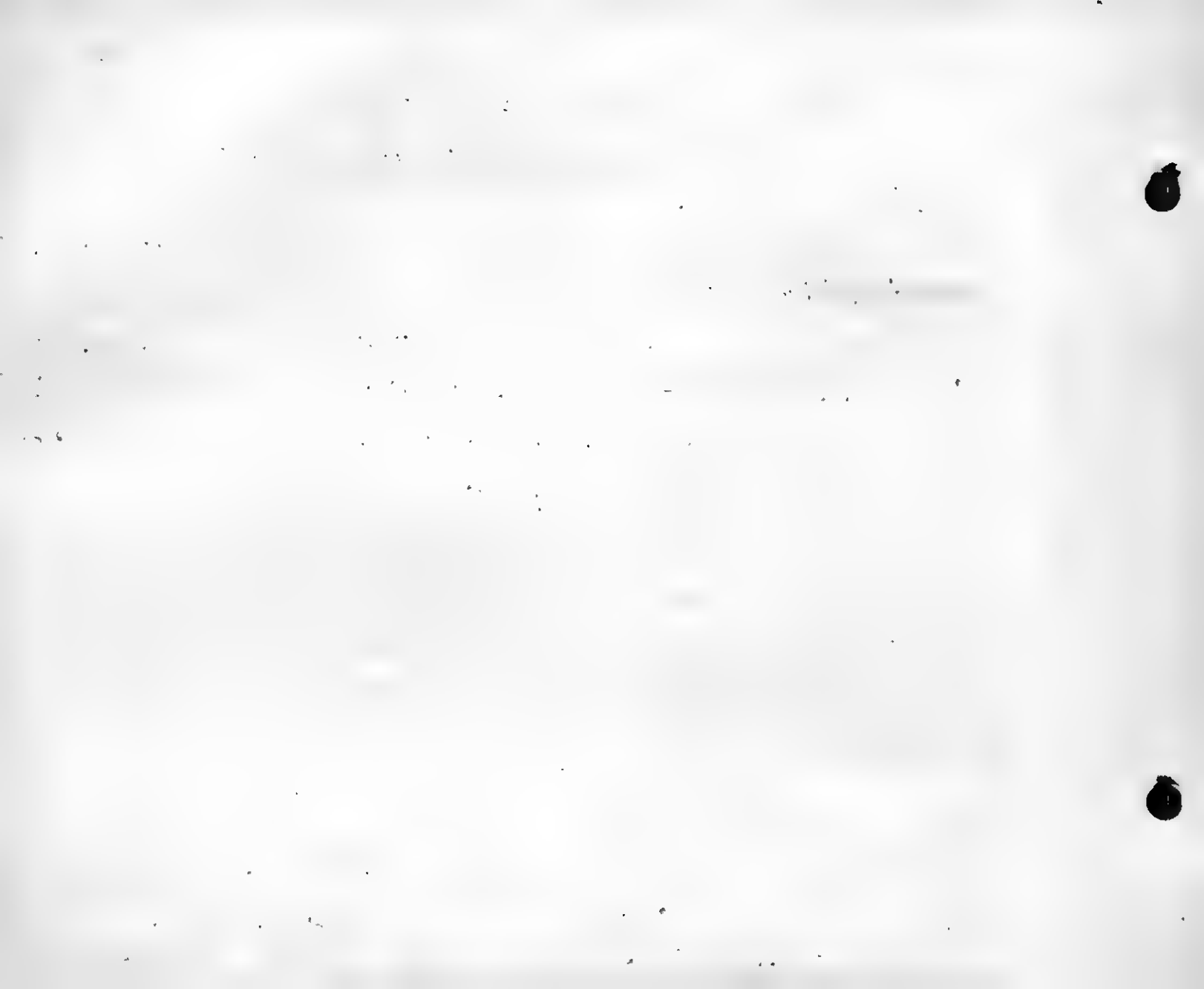
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
Charles Edward Bond						12 Month 19 Day 68 Year		8:10 PM		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Colored		1/4/71		97 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Olney			Montgomery General Hosp.			Laborer - Retired				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery		Silver Sprg.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2720 Norbeck Road	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Thomas Bond			Julie Ann Sedgwick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT					
			577-44-8240		Medical Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>485X</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Arteriosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1968</u> to <u>Dec 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		22c DATE SIGNED								
<u>Richard A. Yates M.D.</u>		12/20/68								
22d PHYSICIAN'S NAME (Type)		22e ADDRESS								
Richard Yates, M.D.		Old Baltimore Road, Olney, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		12-23-68		ASH MEMORIAL CEM		SANDY SPRING Montg Md.				
24 FUNERAL DIRECTOR		24b ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Robert L. Snowden		Rockville Md		DEC 27 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17698					17709				
1 DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR	
DAVID BORACK					12 3 68			3 50 A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUCASIAN		8/14/23		45 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTIMORE MARYLAND		U.S.A.				Montgomery Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		Holy Cross Hospital		BAKER		HEIDE BAKING CO			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				13b. COUNTY		13c CITY OR TOWN		13e STREET AND NUMBER	
STATE MARYLAND				Mont.		Silver Spring		9312 Pine Branch	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
HARRY BORACK					BELLE BOOKBINDER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)					16b SOCIAL SECURITY NO		17 INFORMANT		
YES					U. S. ARMY 217-14-2573		MRS. ANITA BORACK, 9312 PINEY BRANCH RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction									
41-1-1 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thromboses									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
41-1-1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 2, 1968, to Dec 3, 1968, that (I) (we) last saw the deceased alive on Dec 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Dennis G. Bender MD									12/3/68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					HOLY CROSS HOSPITAL, SILVER SPRING				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		12-4-68		RUDOMER VEREIN		ROSEDALE, MARYLAND			
24 FUNERAL DIRECTOR ADDRESS					25a. DEED BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					DEC 6 1968		Charles Judge		





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

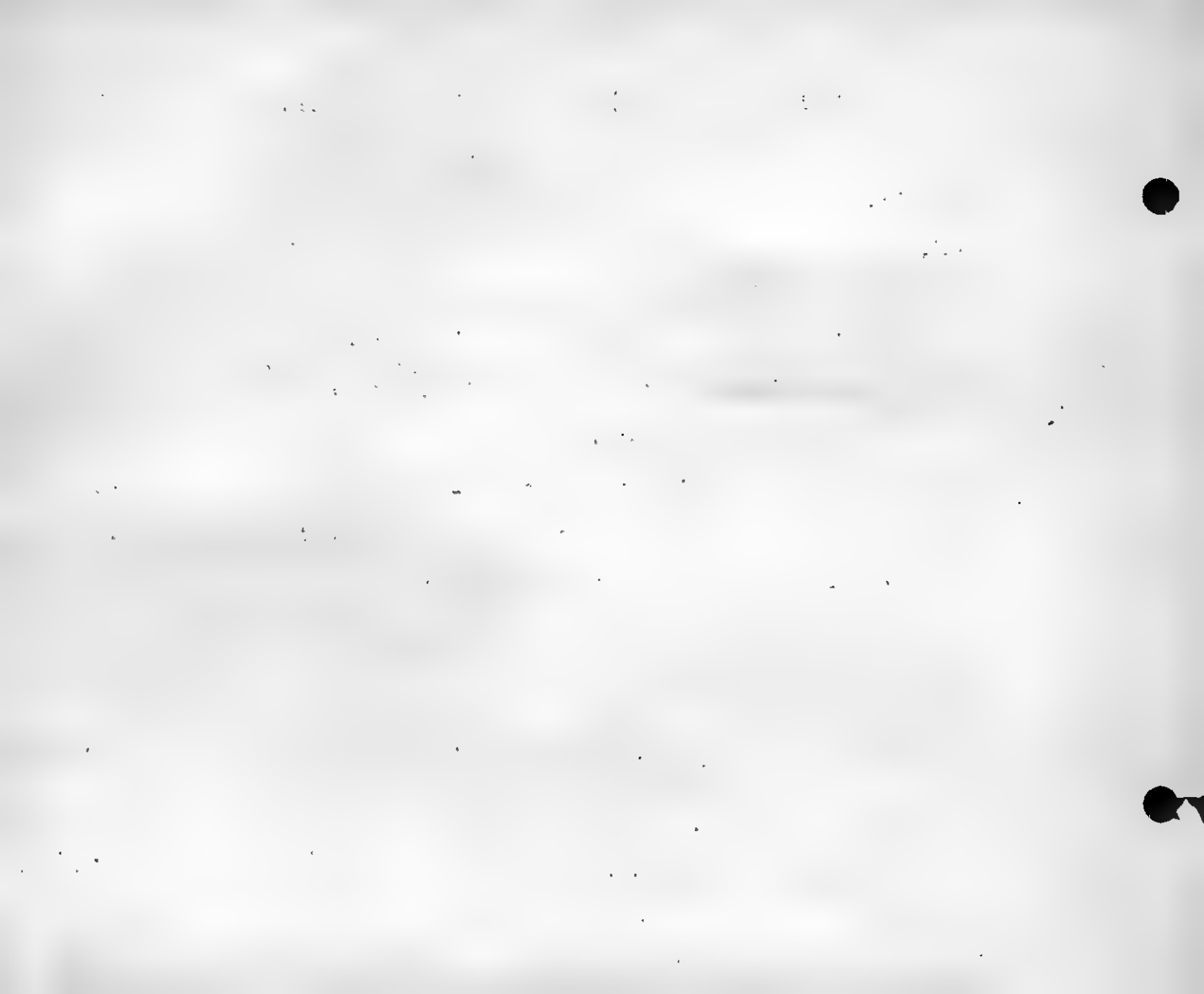
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
Mabel M. Boyles						Dec 21-68			P M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. YEARS	9. MONTHS	10. DAYS	11. HOURS	12. MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
Fe.	W.	Nov. 26, 1907	60 YRS.							Dec. 26	12:30 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md			
Penna		U.S.A.				Montgomery						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda				5807 Aberdeen Rd				HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, MTS?		13e. STREET AND NUMBER		
Md.				Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5807 Aberdeen Rd		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
First Middle Last				First Middle Last								
Maxmillian Sollerger				Elizabeth Deibold								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
NO				Unknown		HUSBAND			SAME AS ITEM 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subsensation -</u>										5 min -		
(and, if any, which gave rise to immediate cause (a) stating the underlying cause last.)												
(b) <u>Breathing in Plastic Bag</u>												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. P.M. Dec 21 1968			Tied. Plastic bag on head -						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State			
Home			Home			5807 Aberdeen Rd. Bethesda			Montgomery Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			12-30-68		St. Augustine's Cem.			Pittsburgh, Penna.				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland								DATE JAN 2 1969		Charles Judge		
26. CHIEF MEDICAL EXAMINER			27. ASSISTANT MEDICAL EXAMINER			28. DEPUTY MEDICAL EXAMINER			29. ADDRESS (Street, city, town, or county)			
John G. Ball						Bethesda, Md.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17720										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17711																																																	
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																	
First <b>William</b>										Middle <b>(NMN)</b>										Last <b>Brainin</b>										Month <b>December</b>										Day <b>10</b>										Year <b>1968</b>										2b. HOUR <b>2:00 M</b>									
3. SEX <b>Male</b>										4 RACE <b>White</b>										5 DATE OF BIRTH <b>1 November 1910</b>										6 AGE (In years last birthday) <b>58</b> YRS.										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country) <b>Connecticut</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH <b>Montgomery</b> Md.																																							
10 CITY OR TOWN OF DEATH <b>Bethesda</b>										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Physician</b>										12b. KIND OF BUSINESS OR INDUSTRY																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>										13b. CITY OR TOWN <b>Prince George Seat Pleasant</b>										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER <b>201 N. Addison Road</b>																																							
14 FATHER'S NAME First <b>Philip</b>										Middle <b>Brainin</b>										Last <b>Brainin</b>										15. MOTHER'S MAIDEN NAME First <b>Fannie</b>										Middle <b>Gaberman</b>										Last <b>Gaberman</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <del>or</del> unknown (If yes give year or dates of service)										16b. SOCIAL SECURITY NO. <b>214-36-4465</b>										17 INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, NIH, Bethesda, Md. 20014</b>																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b>										DUE TO, OR AS A CONSEQUENCE OF (b) <b>Buttock abscess and suspected sepsis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic myelogenous leukemia, blastic phase</b>										<b>2 weeks</b>																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Gastrointestinal bleeding, aortic insufficiency</b>																				<b>5 months</b>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>26 Nov.</b> , 19 <b>68</b> , to <b>10 Dec</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>10 December</b> , 19 <b>68</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>(did not)</del> view the body after death.																																																																					
22b. SIGNATURE <b>Peter Rosen MD</b>										DEGREE <b>MD</b>										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED <b>10 December 1968</b>																																							
22d. PHYSICIAN'S NAME (Type) <b>Peter J. Rosen, M.D.</b>										22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>										23b. DATE <b>12-12-68</b>										23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN FALLS CHURCH VA.</b>										23d. LOCATION (City or Town) (County) (State) <b>VA.</b>																																							
24. FUNERAL DIRECTOR <b>BERNARD Danzansky &amp; Sons</b>										ADDRESS <b>3501-14th Street, N.W. WASHINGTON, D.C. 20010</b>										25a. REC'D BY REGISTRAR <b>DATE DEC 16 1968</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																																							



17701

17712

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or print) First Middle Last <i>Lillabel S. Brand</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>12-21 1968</i>			2b. HOUR <i>4:20 PM</i>	
3. SEX <i>Fe</i>	4. RACE <i>Cauc</i>	5. DATE OF BIRTH <i>1-6-1900</i>	6. AGE (In years last birthday) <i>68</i> YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <i>12-21 1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Rockville</i>		13c. INSIDE CITY L.M. IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>16413 Deerlake Rd.</i>	
14. FATHER'S NAME First Middle Last <i>Adin S. Dexter</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Dittmer</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>059-30-9239</i>		17. INFORMANT <i>Husband</i>		ADDRESS <i>Same as Item 13.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> <i>4/11</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Essential Hypertension</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>9</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Keap</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>DEC. 21, 1968</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. KEAP, M.D.</i>		ADDRESS (City, town, or county) <i>Bethesda, Md.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>12/24/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Pr. Geo. Md.</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REG STRAR DATE <i>JAN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## CERTIFICATE OF DEATH

17713

1 DECEASED NAME (Type or print) <i>James</i> First Middle Last <i>Brown</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>1968</i>			2b. HOUR <i>1:30</i>	
3 SEX <i>male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>10/2/26</i>		6. AGE (In years last birthday) <i>42</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (If not at work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if at institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>James Brown</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Mary Oney</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>			
16b. SOCIAL SECURITY NO		17 INFORMANT <i>Kathleen Louise Green</i> Address <i>504 N Oakwood Rockville Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage, massive, spontaneous</i> <i>4309</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured aneurysm of Circle of Willis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>220X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>18 Dec</i> , 19 <i>68</i> , to <i>19 Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>19 Dec</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Frederick S. Caldwell, MD</i>				22c. DATE SIGNED <i>12/20/68</i>		22d. PHYSICIAN'S NAME (Type) <i>FREDERICK S. CALDWELL, MD</i>	
22e. ADDRESS <i>ROCKVILLE, MD</i>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<i>BURIAL</i>		<i>12-23-68</i>		<i>LINCOLN PARK CEM.</i>		<i>Rockville Montgomery Md.</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i> ADDRESS <i>Rockville Md</i>				25a. REC'D BY REGISTRAR <i>DEC 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR	
Dorothy Mary Louise					Brownyard				Dec. 17 1968		12 PM	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (n years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		April 10, 1912			56 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.			U.S.A.					Montgomery Md				
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Sil. Spring				1606 Noyes Drive				Housewife		own home		
13a U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland				Montgomery		Sil. Spr.		YES		1606 Noyes Drive		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last			
Albert			J.		Wessner, St.				Isabella -- Caldwell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address			
no			Yes			Theodore Brownyard			1606 Noyes Drive Sil. Spr. Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary myocardial disease</u>										5 min		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic myocardial disease</u>										46 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Rheumatic fever</u>										46 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
416X None												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
			P.M. 19									
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 12-17-68 to 12-17-68, that (I) (we) last saw the deceased alive on 12-17-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <u>John S. Rogers M.D.</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 12-17-68				
22d. PHYSICIAN'S NAME (Type) John S. Rogers, M.D.						22e ADDRESS 1919 Secondary Rd. Silver Spring Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			12-20-1968		Baltimore National Cem.			Baltimore, Maryland				
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>Sil. Spr., Md.</u>						25a REC'D BY REGISTRAR <u>DEC 23 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

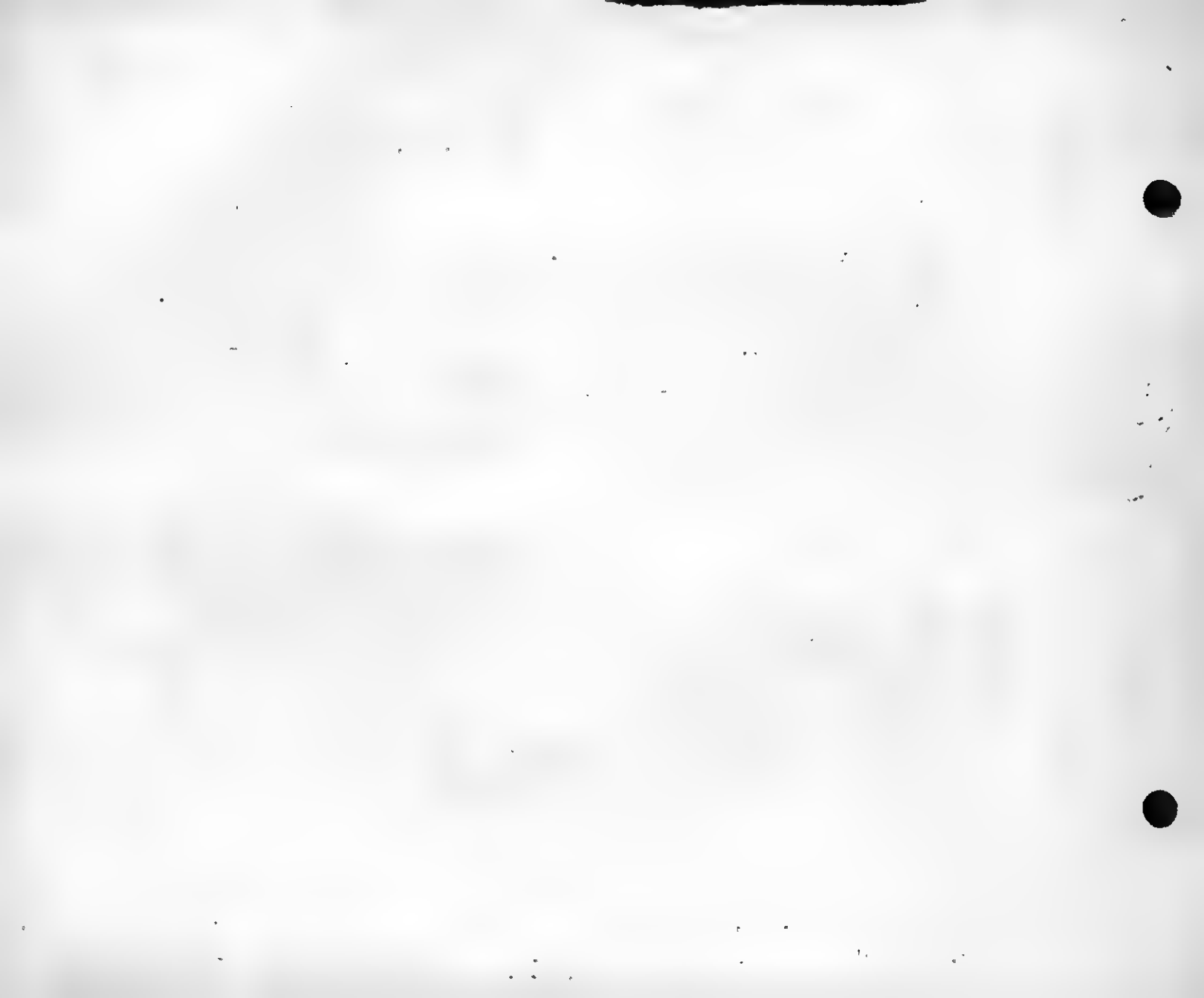
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17704

CERTIFICATE OF DEATH

17715

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Jeanne Baldwin Buell					Dec. Month 14 Day 1968 or		7 45 PM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
Female	White		Sept. 11, 1928		40 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
France	USA				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Chevy Chase		106 Quincy St.		Teacher					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		106 Quincy St.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Joseph C. Baldwin		Marthe Guillon-Verne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		578-42-9115		Martha C. Buell		-HUSBAND			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>OVARIAN CARCINOMA</u>								11-2-15 PM	
1830 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
1756									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2/12/67		CARCINOMA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1968, to 12/14, 1968, that (I) (we) last saw the deceased alive on 12/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
A. J. Breverman M.D.		12/14/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
A. J. Breverman		Chevy Chase, Md.							
23a. BURIAL, CREMATION, or other disposal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		Dec. 16, 1968		Cedar Hill Crematory		Suitland Prince George Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECT'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Jos. Gawler's Sons		5130 Wisconsin Ave. Washington, D.C.		DATE DEC 19 1968		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. DECEASED-NAME (Type or print) <b>Mary</b>		First <b>Mary</b>		Middle <b>Teresa</b>		Last <b>Bulger</b>		2a. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>9:00</b> P		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>21 April 1920</b>			6 AGE (In years last birthday) <b>48</b> YRS.		7E UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7F UNDER 24 HRS HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Examiner</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>New York</b>				13b. COUNTY <b>Little Falls</b>		13c. CITY OR TOWN <b>Little Falls</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>217 Flint Avenue</b>			
14. FATHER'S NAME First <b>John</b> Middle <b></b> Last <b>Restante</b>				15. MOTHER'S MAIDEN NAME First <b>Teresa</b> Middle <b></b> Last <b>Durrn</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, NIH, Bethesda, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sjogren's syndrome</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>8 months</b> <b>12 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>20-21</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that <b>NO</b> (this hospital) attended the deceased from <b>Dec. 17</b> , 1968, to <b>23 Dec.</b> , 1968, that <b>NO</b> (we) last saw the deceased alive on <b>December 23</b> , 1968, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>NO</b> (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Nancy B. Kaltreider, MD</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>24 December 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Henry B. Kaltreider, M.D.</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-25-1968</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) <b>Little Falls, New York</b>					
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., N. W. Wash., D.C., 20016</b>						ADDRESS <b>5130 Wisc. Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5 15 45M

17796		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17717	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First		Middle		Last	
CLIFTON		R.		BURDETTE			
3 SEX		4. RACE		5. DATE OF BIRTH		2a. DATE OF DEATH	
MALE		WHITE		3/18/1900		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.		NEW YORK			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN		TELEPHONE CO.			
13a. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Montgomery		GARTHERSBURG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		First		Middle		Last	
Richard T. Burdette		Laura		Thompson?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		no		Susie		Burdette	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4339		IMMEDIATE CAUSE (a) <u>Bronchopneumonia (Klebsiella-Aerobacter)</u>		3 weeks			
Died at home, if any, which gave rise to immediate cause (c), stating the underlying cause last		(b) <u>Cerebral Infarcts old &amp; recent</u>		Weeks to years			
		(c) <u>Cerebral arteriosclerosis</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
none							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 4, 1968</u> to <u>Dec. 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Joseph A. Romeo MD		12/21/68		Joseph A. Romeo MD			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
8218 Wisc. Ave.		Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12/23/1968		Neelsville Ch. Cem.		Neelsville, Montg. Md.	
24. FUNERAL DIRECTOR		1331 ADDRESS		REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home		Rockville, Md.		DEC 26 1968		Charles Judge	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 408  
1-15-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17718

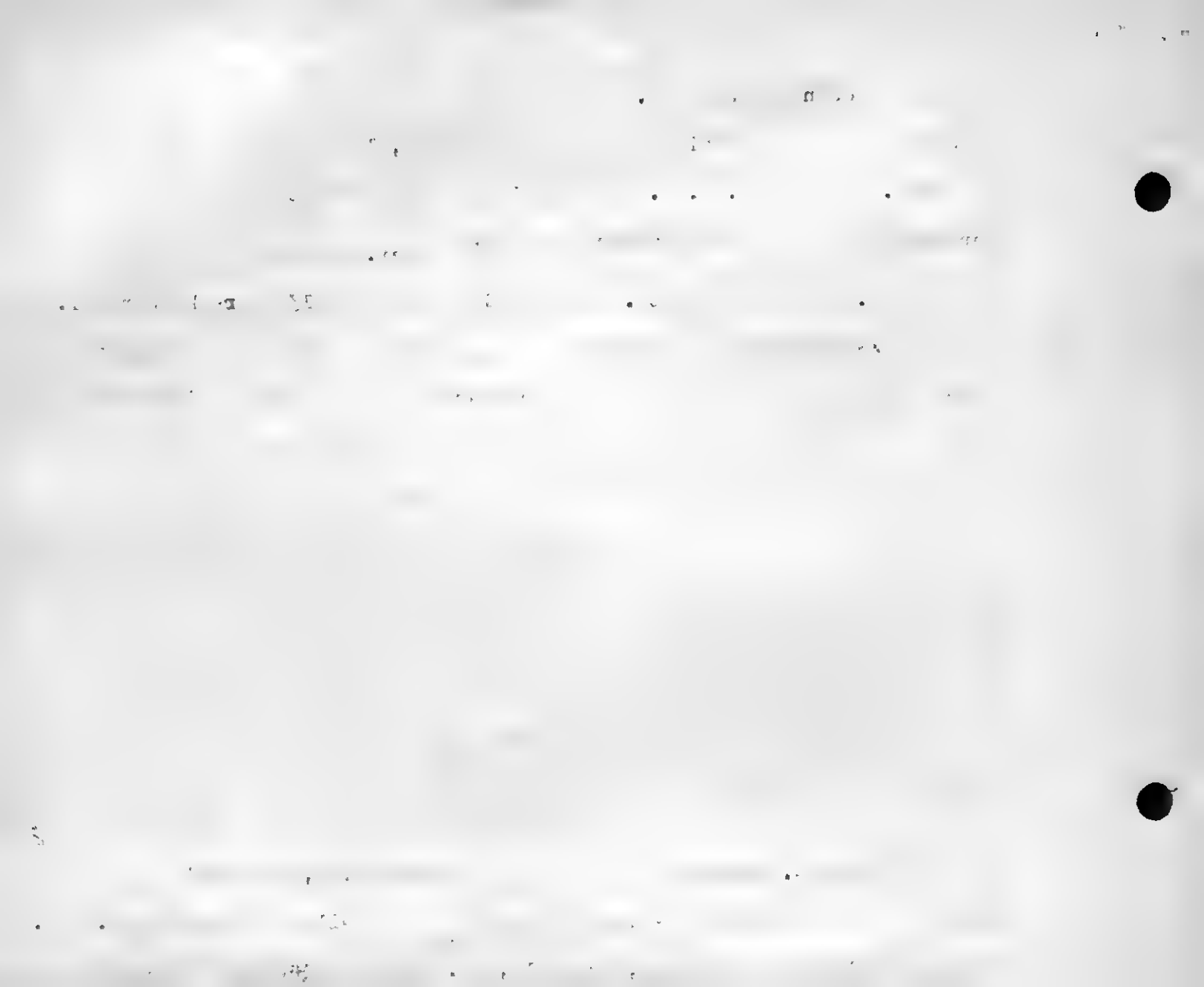
1 DECEASED NAME (Type or Print) <i>Clifford Clave Burnett</i>			2a DATE KNOWN OF ESTI- DEATH MATED <i>Dec. 3 1968</i>			2b HOUR <i>A M</i>			
3 SEX <i>M</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH <i>Jan 27-1933</i>	6 AGE (In years last birthday) <i>35</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i>	DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>Dec. 3</i> Day <i>3</i> Year <i>1968</i>	2d HOUR <i>8 45</i> <i>A M</i>
7a BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.			
10 CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <i>10 E Diamond Ave Gaithersburg</i>		12a USUAL OCCUPATION and of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution on address) STATE <i>Md</i> COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Gaithersburg</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>10-E Diamond Ave.</i>			
14 FATHER'S NAME First <i>George</i> Middle <i>Burnett</i> Last <i>Burnett</i>			15 MOTHER'S MAIDEN NAME First <i>Marie</i> Middle <i>Shupe</i> Last <i>Shupe</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Peggy Hepsley</i> ADDRESS <i>7504 Manchester Mill Rd Gaithersburg</i>				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> Pulmonary edema, Acute <i>1509</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs. ?</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>971.8</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. ? P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Took overdose of some drugs</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>10 E. Diamond Ave.</i> City or Town <i>Gaithersburg</i> County <i>Montg.</i> State <i>Md.</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John B. Ball</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Dec. 4, 1968</i>			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-6-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>		23d. LOCATION (City or Town) (County) (State) <i>Towles Pa</i>			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>		ADDRESS <i>Ernest C. Gartner, Gaithersburg</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17798		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17719					
1. DECEASED NAME (Type or print)		First <b>JOHNXX John</b>		Middle <b>T.</b>		Last <b>BURNS</b>		2a. DATE OF DEATH Month <b>Dec</b> Day <b>28</b> Year <b>1968</b>		2b. HOUR <b>12:30</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 3, 1893</b>		6. AGE (In years birthday) <b>75</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Germantown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>Marylander Rest Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ret. Printer</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>11303 Creek Shore Pl.</b>			
14. FATHER'S NAME First <b>MR James</b> Middle <b>NMC</b> Last <b>Burns</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Barnett</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Name <b>Lee Burns</b> Address <b>Same as item 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Atherosclerosis of coronary arteries</b> DUE TO, OR AS A CONSEQUENCE OF lost (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sustained</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Advanced arteriosclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>27 Jan, 19 67, to 28 Dec, 19 68</b> , that (I) (we) last saw the deceased alive on <b>Dec 10 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John G. Fawcett</b>		22c. DATE SIGNED <b>12/28/68</b>		22d. PHYSICIAN'S NAME (Type) <b>John G. Fawcett</b>		22e. ADDRESS <b>Dawsonville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/31/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Montg. Md.</b>					
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		1331 ADDRESS <b>Rockville Pike</b>		25a. REC'D BY REGISTRAR <b>Jan 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17720					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or Print) <u>Stanley</u>			First <u>F</u>		Middle <u></u>		Last <u>Buerous</u>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <u>Dec 25</u> 19 <u>68</u>		2b. HOUR <u>2</u> M <u>P</u>				
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH		6. AGE (In years last birthday) <u>71</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN <u></u>		2c. DATE PRONOUNCED DEAD Month <u>Dec</u> Day <u>25</u> Year <u>1968</u>		2d. HOUR <u></u> M <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>Ill.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u>			Md			
10. CITY OR TOWN OF DEATH <u>Bethesda.</u>				11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) <u>5519 Pollard Rd.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda.</u>		13d. INSIDE CITY (L.H. 15?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5519 Pollard Rd.</u>					
14. FATHER'S NAME First <u>Unknown</u> Middle <u></u> Last <u></u>						15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last <u></u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16b. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>LOUIE D. CHAMBERS</u>				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, Cerebral.</u> <u>412.4</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arterio Sclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>years</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u></u> P.M. <u>19</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>Dec 28, 1968</u>							
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXX</u>				23b. DATE <u>1-6-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville Montgomery Md.</u>						
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						ADDRESS <u>7557-Wisconsin Ave., Bethesda, Md.</u>			25a. REC'D BY REGISTRAR <u>JAN 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>				



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) <i>Garland</i> First <i>E</i> Middle <i>Burton</i> Last			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>Dec 18 1968</i>				2b HOUR <i>9:12</i> M		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>4/28/66</i>	6 AGE (in years lost birthday) <i>2</i> YRS	7 UNDER YEAR MONTHS	8 YEAR DAYS	9 UNDER 24 HRS HOURS	10 MIN	2c DATE PRONOUNCED DEAD Month <i>Dec</i> Day <i>18</i> Year <i>1968</i>	2d HOUR <i>9:12</i> M
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before adm'ssion) STATE <i>Md</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>600 Blanford St.</i>	
14 FATHER'S NAME <i>Garland</i> First <i>Burton</i> Middle <i>Pauline</i> Last <i>Shipplatt</i>			15 MOTHER'S MAIDEN NAME <i>Pauline</i> First <i>Shipplatt</i> Middle <i>Shipplatt</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Gaudin Burton</i> ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Anoxia</i>									<i>3 min.</i>
DUE TO, OR AS A CONSEQUENCE OF									
(b) <i>Breathing in Plastic Bag</i>									<i>5 min.</i>
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year <i>9 AM 12/18 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Child put plastic bag over head -</i>				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f LOCATION Street or RFD No. <i>600 Blanford St</i> City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John B. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Dec. 18, 1968</i>			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>12-21-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Flowery Hill Church</i>		23d. LOCATION (City or Town) <i>Piedmont</i> (County) <i>Montgomery</i> (State) <i>Md</i>			
24 FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS <i>Calithersburg, Md.</i>		25a REC'D BY REGISTRAR <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Yunge</i>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10711

## CERTIFICATE OF DEATH

17722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

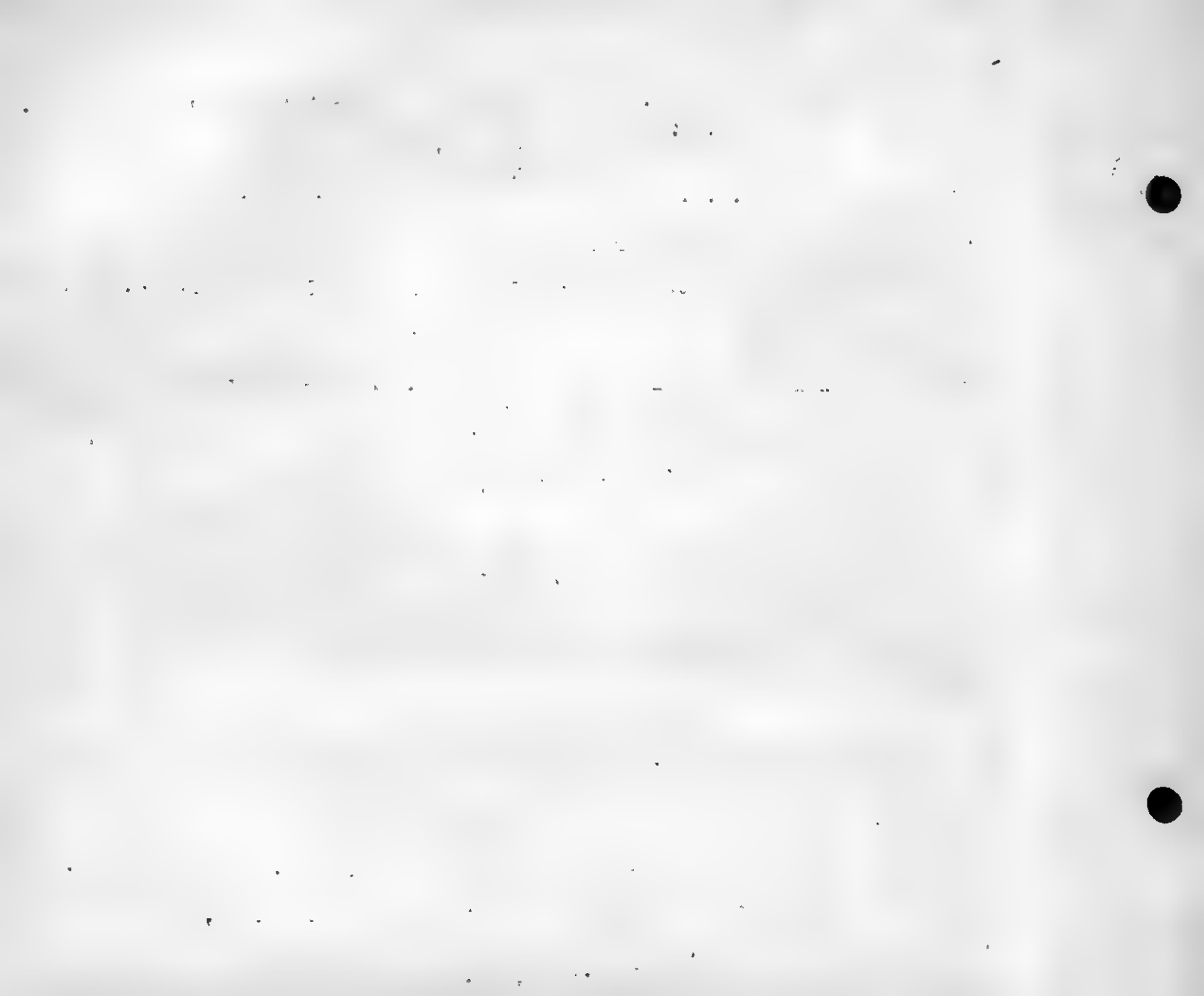
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Monoc</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>8801 Glenville</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Butker</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Butker</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Pauferback</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>200075074</u>	
17. INFORMANT <u>Walter Robbins</u>		Address <u>8801 Glenville Silver Spring Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocardial Infarction</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 yrs 24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>68</u> , to <u>12/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>68</u> , and that death occurred at <u>3:10</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Howard Mouse</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/24/68</u>
22c. PHYSICIAN'S NAME (Type) <u>Howard Mouse MD</u>		22d. ADDRESS <u>7030 Carroll Ave Thomas Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 27 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Winnsboro</u>	23d. LOCATION (City or Town) (County) (State) <u>Pittsburgh Pa</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 30 1968</u>	
ADDRESS <u>254 Carroll St - DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17723 CERTIFICATE OF DEATH 17723											
1. DECEASED-NAME (Type or print)			First ELLA		Middle C.		Last BUTLER		2a. DATE OF DEATH Month 19, Day 68 Year 12:45 P.M.		
3. SEX Female		4. RACE White			5. DATE OF BIRTH May 14, 1905			6. AGE (In years 69 birthday)		7. UNDER YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Clerk			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11113 Midvale Rd. Kensington Maryland	
14. FATHER'S NAME First Middle Last Garrett Cooley			15. MOTHER'S MAIDEN NAME First Middle Last Effie Mills								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 578-24-0903			17. INFORMANT Address Wilton L. Butler-husband same item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 41 7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) Atherosclerosis of heart disease stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Carcinoma, metastatic											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov 1968, to Dec 1968, that (I) (we) last saw the deceased alive on Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George S. Hodge M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/19/68		
22d. PHYSICIAN'S NAME (Type) George S. Hodge M.D.			22e. ADDRESS 10511 Summit Ave. Kensington, Md.								
23a. BURIAL, CREMATION, or other disposition Burial			23b. DATE 12/21/68			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Maryland		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home			ADDRESS 1351 Rock Pike Rockville, Md.			25a. REC'D BY REGISTRAR DATE DEC 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17724									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Flor A Saloma Butler						12 3 68			620 <sup>th</sup> M
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Female		CAUCASIAN		8-14-1889		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		Md.	
Wash. D.C.		U.S.A.		WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		OWN HOME	
Cherry Chase		Siloma Springs Washington		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Mont.		Bessington		YES <input type="checkbox"/> NO <input type="checkbox"/>		3603 PERRY AVE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Herbert - Ellsworth			Mary - Clark						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
no			579-22-7824-A		Lawrence J. Butler		Kensington, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic brain tumor									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Hypernephroma left kidney									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
13 X Arteriosclerotic heart disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No					
22a. I certify that (I) (this hospital) attended the deceased from 1959, 19, to Dec. 2, 1968, that (I) (we) last saw the deceased alive on December 1, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Elaine W. Murphy, M.D.								December 2, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Elaine W. Murphy, M.D.				4812 Elliott St. NW					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		12-5-1968		Parklawn Cemetery		Rockville		Montgomery Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C. Glen Carter				Sil. Spr. Md.		DEC 3 1968		Richard Judge	
Warner E. Pumphrey, Inc. 8434 Georgia Avenue									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 1/58  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Margaret Phee Buzzell						Month Day Year			5 43 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Fe	W.	May 28, 1934	34 YRS.	MONTHS	DAYS	HOURS	MIN	Month Day Year	1968 6 30 PM		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Illinois			U.S.A				Montgomery Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg			19115 Roman Way								
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.			Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19115 Roman Way.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JOHN JAMES PHEE			BETH BATTLES								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
			353-28-3788		WARD V. BUZZELL, HUSBAND, SAME AS #13A.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Post Partum Hemorrhage..										10 MIN.	
653X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Atony of Uterus and laceration of Vaginal Wall..										10 MIN.	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
675X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MED. CAL EXAMINER			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			Dec-10, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Cremation			12-11-1968		Cedar Hill Crematory			Suitland, Prince Georges Co., Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016						DATE DEC 19 1968		J. Charles Judge			





## CERTIFICATE OF DEATH

17725

17726

1 DECEASED-NAME (Type or print) <b>OWEN R BYRD</b>		3a. DATE OF DEATH Month <b>Dec</b> Day <b>4</b> Year <b>1968</b>		2b. HOUR <b>1:40 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Oct. 30, 1892</b>	6 AGE (in years last birthday) <b>76</b> YRS.	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>W. Virginia</b>	7b CITIZEN OF WHAT COUNTRY? <b>United States</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL OR INST. (If not a hospital, give street address) <b>Suburban Hosp</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. INDUSTRY OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5605 ALDERBROOK CT.</b>
14. FATHER'S NAME First <b>Haley</b> Middle <b>Brady</b> Last <b>Pay</b>	15. MOTHER'S MAIDEN NAME First <b>Helen</b> Middle <b>Wheeler</b> Last <b>Pay</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>yes</b> (If yes give year or dates of service) <b>1942-44</b>	16b. SOCIAL SECURITY NO <b>270-50-076</b>	17. INFORMANT <b>Hubert A. G. White</b> Address <b>1111...</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, recent and old, left myocardium and septum</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 1944, to <b>Dec</b> , 1948, that (I) (we) lost saw the deceased alive on <b>3 Dec</b> , 1948, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE <b>Eugene P. Libre MD</b>	22c. DATE SIGNED <b>4 Dec 1948</b>	22d. PHYSICIAN'S NAME (Type) <b>EUGENE P. LIBRE</b>		
22e. ADDRESS <b>10400 Conn. Ave KENSINGTON Md. 20795</b>	22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/6/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Winchester National</b>	23d. LOCATION (City or Town) <b>Winchester Virginia</b>	(County) (State)
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>	24b. ADDRESS <b>1551 Rockville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Julia Ann Callahan</b>			2a. DATE OF DEATH Dec 23 1968			2b. HOUR 10:30 PM				
3. SEX F			4. RACE Cauc			5. DATE OF BIRTH 1/8/1883			6. AGE (in years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. DC			7b. CITIZEN OF WHAT COUNTRY? USA			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash DC			13b. COUNTY Montgomery			13c. CITY OR TOWN Wheaton			13d. STREET AND NUMBER 321C Street NE	
14. FATHER'S NAME Patrick McGill			15. MOTHER'S MAIDEN NAME Mary Callahan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If you give year or dates of service) No			16b. SOCIAL SECURITY NO. 517-07-620	
17. INFORMANT John W. - son			18. ADDRESS 9326 Limestone Pl., Cl. Pk. Md.			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal Unemia; Nephroses</b> 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Diabetes and generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			20c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21d. LOCATION Street or RFD No City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No City or Town County State			21g. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
22a. I certify that (I) (this hospital) attended the deceased from 12-4, 1968, to 12-23, 1968 that (I) (we) last saw the deceased alive on 12-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Pedro I. Matias, M.D.			22c. DATE SIGNED 12/23/68			22d. PHYSICIAN'S NAME (Type) PEDRO I. MATIAS, M.D.	
22b. SIGNATURE Pedro I. Matias, M.D.			22c. DATE SIGNED 12/23/68			22d. PHYSICIAN'S NAME (Type) PEDRO I. MATIAS, M.D.			22e. ADDRESS 4712 Montgomery Pl. Beltsville Md	
23a. BURIAL, CREMATION, REMOVA (Specify) Burial			23b. DATE 12-27-1968			23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Lee Fun. Home 300 4th St. NE Wash., D.C.			25a. REC'D BY REGISTRAR DATE DEC 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			25c. DATE DEC 30 1968	



Clear to Dr. Papp.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH																			
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR							
Frank (Franco)			--		Calvisi		12-17-68			Month Day Year		7:00 M							
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			White			10-17-1903			25 YRS			MONTHS DAYS		HOURS MIN					
7a BIRTHPLACE (State or foreign country)			7b. CIT ZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
Italy			U.S.A.						Montgomery Md.										
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY										
Takoma Park			Washington San & Hosp.			Merchant			Retail										
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER							
Md.			Montgomery			Sil. Spr.			YES			510 Wolf Dr.							
4. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First		Middle		Last			
Dominic					Calvisi				Rubina			(Unknown)							
6a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address										
NO			--			578-26-9945			Emilia Calvisi 510 Wolf Drive, Sil. Spr. Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis												Distinct							
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis												10 yrs							
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis												10 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
5701																			
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)										
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)						21f LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1939, to 12/11, 1968, that (I) (we) last saw the deceased alive on 12/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b SIGNATURE			22c DATE SIGNED						22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
C. LEONARDO			12/11/68						C. LEONARDO					5801-13th St NW Wash. DC					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			24. FUNERAL DIRECTOR			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Burial			12-14-1968			Gate of Heaven Cemetery			Sil. Spr. Montgomery Md.			Warner E. Pumphrey, Inc.		8434 Georgia Ave		DEC 16 1968		Charles Judge	



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VR 15 (4)  
304 REV. 1/68

MARTLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17718											
17729											
1. DECEASED NAME (Type or print) First Middle Last MARION ELIZABETH CARLISLE						2a. DATE OF DEATH Month Day Year Dec 2 1968			2b. HOUR - MIN. 12:30 PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH Jan 6, 1909		6. AGE (In years last birthday) 59 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE md			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14004 Trawilah Rd		
14. FATHER'S NAME First Middle Last Nick Nibholson				15. MOTHER'S MAIDEN NAME First Middle Last Minnie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Clifton C. Carlisle husband's name it					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 1963, to 12-2, 1968, that (I) (we) last saw the deceased alive on 12-2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. L. Bucy / S. N. JONES						DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-2-68	
22d. PHYSICIAN'S NAME (Type) DL Bucy / S. N. JONES						22e. ADDRESS 809 Veers Mill Rd Rockville Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/4/68		23c. NAME OF CEMETERY OR CREMATORY Forest Oak			23d. LOCATION (City or Town) (County) (State) Gaithersburg, Maryland				
24. FUNERAL DIRECTOR E. yson heeler funeral home				ADDRESS 1 Rockville, Md		25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 408 1-20 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

177219

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17730

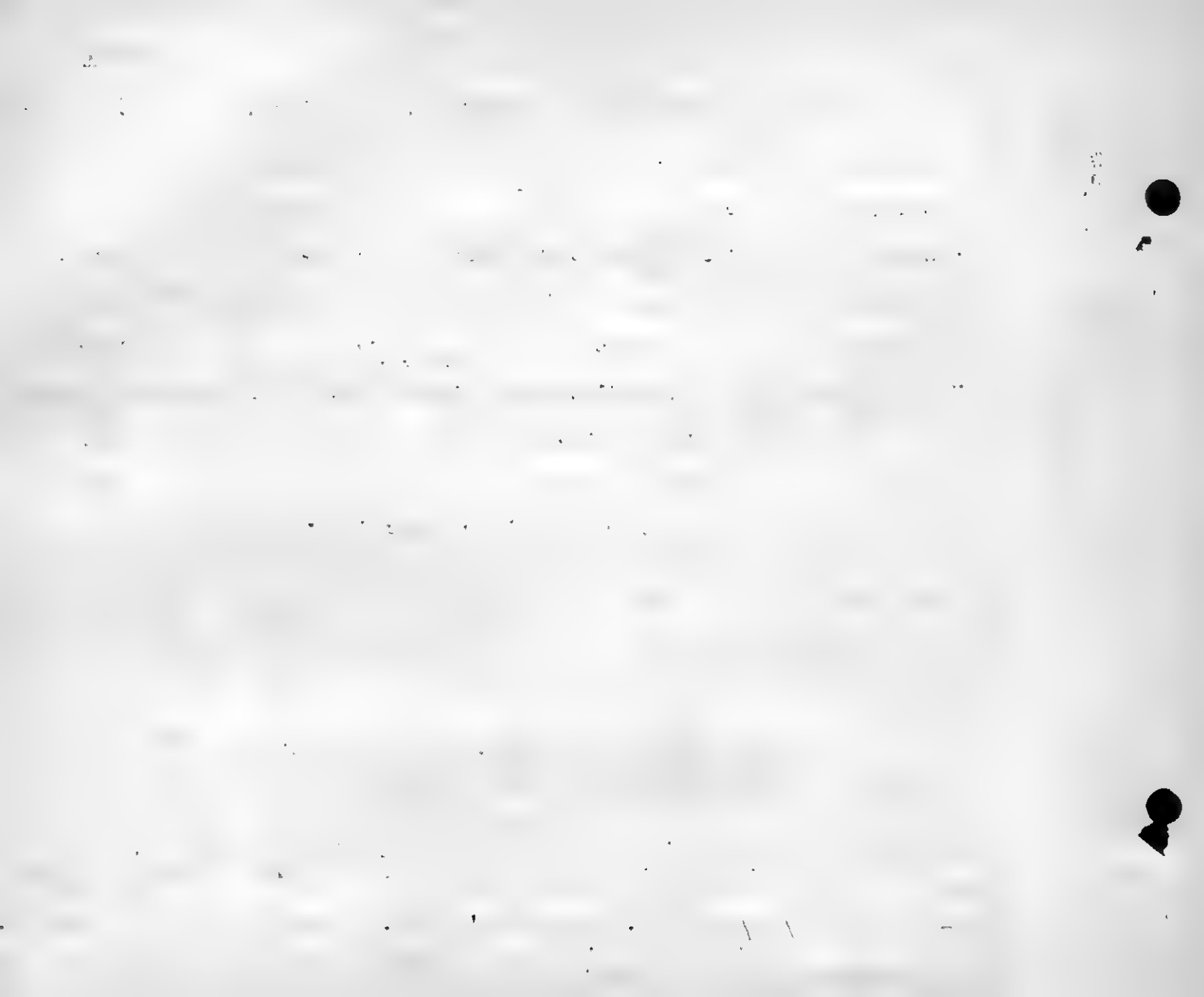
1 DECEASED NAME (Type or Print) <u>James Carr</u>			First Middle Last			2a DATE KNOWN OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1968</u>			2b HOUR <u>12:15</u>		
3 SEX <u>M</u>	4 RACE <u>W</u>	5. DATE OF BIRTH <u>12-20-76</u>	6 AGE (In years last birthday) <u>1</u> YRS	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	2c DATE PRONOUNCED DEAD Month <u>12</u> Day <u>21</u> Year <u>1968</u>			2d HOUR <u>12:15</u>		
7a BIRTHPLACE (State or foreign country) <u>Montgomery</u>			7b CITIZEN OF WHAT COUNTRY? <u>USA</u>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <u>Montgomery</u>		
10. CITY OR TOWN OF DEATH <u>Rockville</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <u>Washington</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u> COUNTY <u>Mont</u>			13b. CITY OR TOWN <u>Rockville</u>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER <u>6500 Riggs Rd</u>		
14. FATHER'S NAME First Middle Last <u>James Carr</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Helena Walsh</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16b. SOCIAL SECURITY NO. <u>577-07-3336</u>		
17. INFORMANT <u>Wm. Chert</u>			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerotic Heart Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <u>12-10-1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Deceased fell &amp; hit left hip in nursing home</u>			21d. LOCATION Street or R.F.D. No. <u>6500 Riggs Rd</u> City or Town <u>Hyattsville</u> County <u>Pr. George</u> State <u>MD</u>		
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>			21f. LOCATION Street or R.F.D. No. <u>6500 Riggs Rd</u> City or Town <u>Hyattsville</u> County <u>Pr. George</u> State <u>MD</u>			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED <u>DEC. 25, 1968</u>		
ACTUAL SIGNATURE <u>Golden P. Bean, M.D.</u>			EXAMINER'S NAME (Type) <u>Golden P. Bean, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>DEC. 25, 1968</u>		
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>12-29-68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>			23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>		
24. FUNERAL DIRECTOR <u>HANSON FUNERAL HOME</u>			ADDRESS <u>WASH. DC</u>			25a. REC'D BY REGISTRAR <u>JAN 2 1969</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P
Alfred			Gabriel	Carter, Sr.	December 10 1968			4:45 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		28 June 1913		55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Mo.
Pennsylvania		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Physician		Medicine	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, J.M.T.S?		13e. STREET AND NUMBER
Pennsylvania					Scranton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		821 North Irving Avenue
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Alfred			Carter	Agnes			McLaughlan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
Yes			1942-1946		The Medical Record Address Not available The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1541 DUE TO, OR AS A CONSEQUENCE OF Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Adenocarcinoma of the rectum & sigmoid colon (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Nov. 6, 1968, to Dec. 10, 1968, that (X) (we) lost saw the deceased alive on December 10, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William C. Wood M.D.					22c. DATE SIGNED 11 December 1968		22d. PHYSICIAN'S NAME (Type) William C. Wood, M. D.		
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Rem-bur		12/12/68		St. Catherine's Cem.		Moscow, Penna			
24. FUNERAL DIRECTOR C. M. Ziegler					25a. REC'D BY REGISTRAR DEC 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5219 Marlyn Drive</b>		d. STREET ADDRESS <b>5219 Marlyn Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Olive</b> Middle <b>M.</b> Last <b>CAVE</b>		4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1968</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-30-1905</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>James L. Mothershead</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>577-07-4534</b>	
17. INFORMANT <b>Mr. Robert L. Cave, Husband, same as item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastases (Osseous/Pulmonary)</b> <b>174x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of The Breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>17 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>17 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 7, 1968</b> , to <b>December 18, 1968</b> , that I last saw the deceased alive on <b>December 17, 1968</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Gustafson</b>		M.D. <b>915 19th Street, N.W.; Washington, D.C. 12-18-68</b>	
PHYSICIAN'S NAME (Type) <b>John F. Gustafson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-20-1968</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Prince Georges Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>		24a. REC'D BY REGISTRAR <b>DEC 23 1968</b>	
		24b. REG STRAR'S SIGNATURE <b>Williamas Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

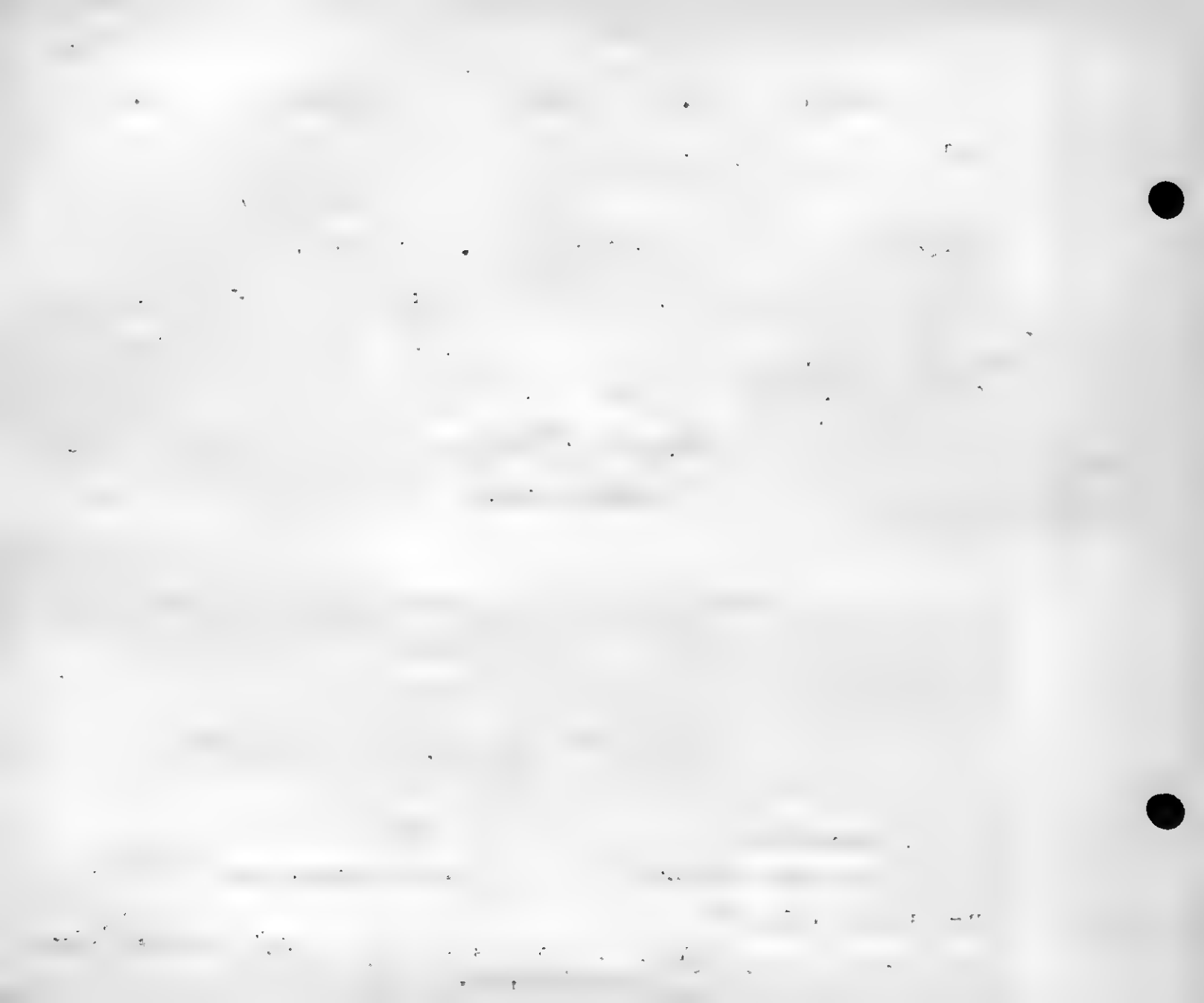
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17732		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17733	
1 DECEASED-NAME (Type or print) <b>Antonio R. Chagas</b>						2a. DATE OF DEATH <b>December 21 1968</b>	
3 SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6/25/94</b>		2b. HOUR <b>9:45 A M</b>	
7a. BIRTHPLACE (State or foreign country) <b>BRAZIL</b>		7b. CITIZEN OF WHAT COUNTRY? <b>BRAZIL</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Physician</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1727 EVELYN DR</b>		14. FATHER'S NAME First <b>CARLOS</b> Middle <b>E</b> Last <b>SILVA</b>		15. MOTHER'S MAIDEN NAME First <b>Lidia</b> Middle <b>BARBOSA</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>SON - JOSE P. CHAGAS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>2.4 h</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/20/68</b> 19, to <b>12/21/68</b> 19, that (I) (we) last saw the deceased alive on <b>12/21/68</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ronald W. Barr</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>RONALD W. BARR</b>				22e. ADDRESS <b>10401 OLD GEORGETOWN RD BETHESDA, MD</b>			
23a. BURIAL CREMATION <b>Burial</b>		23b. DATE <b>12/24/1968</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>Brazil</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>				1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b> REGISTRAR <b>James Judge</b>	





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Carl</i>			First <i>Carl</i> Middle <i>Christensen</i> Last <i>Christensen</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>8</i> Year <i>68</i>			2b. HOUR <i>10 AM</i>		
3 SEX <i>Male</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>6/2/81</i>		6. AGE (in years last birthday) <i>87</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Danvers, Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired-Carpenter</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INS DE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4621 Maple Ave</i>		
14. FATHER'S NAME First <i>Unknown</i> Middle <i></i> Last <i></i>			15 MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i></i> Last <i></i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>			16b. SOCIAL SECURITY NO <i>223-26-8542</i>			17 INFORMANT <i>Daughter Mrs John Pope</i>			Address <i>Home</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhagic Gastritis</i>											
185X DUE TO, OR AS A CONSEQUENCE OF											
(b) <i>Cardioma Prostate</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Metastatic Ca</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1777											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i></i> Day <i></i> Year <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>12-8-1968</i> , to <i>12-8-1968</i> , that (H) (we) lost saw the deceased alive on <i>12-8-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Delwitt E De Lanter</i>			DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>12-8-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Delwitt E De Lanter M.D.</i>			22e. ADDRESS <i>3848 Porter St NW WASH DC</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12-10-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Washington Mem. Park</i>			23d. LOCATION (City or Town) (County) (State) <i>Richmond, Virginia</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>			ADDRESS <i></i>			25a. REC'D BY REGISTRAR DATE <i>DEC 16 1968</i>			25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15  
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>ELLIS A. CLAGETT</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>Dec 19 1968</b>			2b. HOUR <b>3:30 PM</b>
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>11/24/06</b>			6 AGE (in years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTH-PLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		3d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>21 KANDOLPH AVE</b>	
14. FATHER'S NAME First Middle Last <b>Charles Clagett</b>			15. MOTHER'S NAME First Middle Last <b>Cora Allison</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>21610-2341</b>		17. INFORMANT <b>Daughter in law - Mrs Edna Clagett</b> Address <b>21 Kandolph Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma with metastasis to brain, adrenals, spleen and lymph nodes</b> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1621 Pneumonia of acute onset (24 hours)</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>11 Dec 1968</b> to <b>19 Dec 1968</b> , that (I) (we) last saw the deceased alive on <b>19 Dec 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frederick S Caldwell MD</b>					OEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STATE PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12/30/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>FREDERICK S CALDWELL</b>					22e. ADDRESS <b>ROCKVILLE MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Smithland Md</b>			
24. FUNERAL DIRECTOR <b>Wm. Chambers Co</b>					ADDRESS <b>Silver Spring Md</b>		25a. REC'D BY REGISTRAR <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
Item 13a, b, c, e, Film 3407 12/11/68											
17736											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Elmer Edwin Clayton						Month 12 Day 3 Year 1968			9:40 AM		
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
male		White		7-4-91		27 YRS.					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Vermont		U.S.A.				Montgomery Md.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park Md			Washington San. & Hospital			Book binder			Printing House		
13a U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Montgomery		Takoma Park				7706 Garland Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Edwin Clayton			Laurentine Atwood								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT		Address				
Yes, no, or unknown			?		Pts chart						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>IntraCerebral Hemorrhage, massive</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular-Cerebral Dis.</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
<u>3 weeks</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>4221</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>July 1968</u> , to <u>Dec 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE <u>James H. [Signature]</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
								12-3-68			
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
						7717 Carroll Ave Takoma Park Md					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
		Dec 5, 1968		Rock Creek		Washington		D.C.			
24. FUNERAL DIRECTOR <u>Robert Walters Washington D.C.</u>						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
						DATE DEC 6 1968		<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR 15-14  
30M REV 1-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17737

1. DECEASED NAME (Type or print) <b>Edgar Frick Clemens</b>			2a. DATE OF DEATH <b>Dec. 18 1968</b>		2b. HOUR <b>P</b> <b>8:40 M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>6/14/05</b>		6. AGE (In years lost birthday) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Penn.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PBX installer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm ssion) STATE <b>Maryland</b>	13b. COUNTY <b>Montg.</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1115 Lewis avenue</b>	
14. FATHER'S NAME <b>John S. Clemens</b>		15. MOTHER'S MAIDEN NAME <b>Lillian Irene Yeager</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or Unknown <input type="checkbox"/> (If yes give year or dates of service) <b>WW II</b>		16b. SOCIAL SECURITY NO <b>212-10-0492</b>		17. INFORMANT <b>Records</b> Address <b>Montgomery General Hospital, Olney, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cirrhosis of liver - active</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b> <b>yes.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>581</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-6-1968</b> , to <b>12-18, 1968</b> , that (I) (we) lost saw the deceased alive on <b>12-18 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Frederick Moomau, M.D.</b>		22c. DATE SIGNED <b>Dec. 18, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Frederick Moomau, M. D.</b>	
22e. ADDRESS <b>Sandy Spring, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE <b>12/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>		ADDRESS <b>Funeral Home-1331 Rockville Pike</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>	
		<b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>Mary E. CLOWER</b>		2a. DATE OF DEATH Dec. Month 3 Day 68 Year <b>17738</b>		2b. HOUR <b>235PM</b>	
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 24, 1926</b>	
6. AGE (In years last birthday) <b>42</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Mississippi</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>		10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	
13b. COUNTY <b>Pr. George</b>		13c CITY OR TOWN <b>Bowie</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>12915 Bently Lane</b>		14 FATHER'S NAME First Middle Last <b>R Q Turner</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lou Butler</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>428 34 9984</b>		17 INFORMANT Address Md. <b>LCDR W. E. CLOWER, 12915 Bently Lane, Bowie</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breasts with metastases.</b> <b>114X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>170X</b>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (a) (this hospital) attended the deceased from <b>Nov. 8, 1968</b> to <b>Dec. 3, 1968</b> , that (x) (we) last saw the deceased alive on <b>Dec. 3, 1968</b> and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Thomas M. Schenk M.D.</b>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <b>Dec. 4, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Thomas M. Schenk, M.D.</b>		22e ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/4/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>East Fork Cemetery</b>	
23d LOCATION (City or Town) (County) (State) <b>Smithdale Mississ-</b>		24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home, 7557 Wisconsin Ave. Bethesda Md</b>			
25a REC'D BY REGISTRAR <b>DEC 9 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17728										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17739									
1 DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										Hour									
Christian Hessler COCHRAN										Dec. 15 68										430P M									
3 SEX										4. RACE										5. DATE OF BIRTH									
Male										Caucasian										Apr. 1, 1917									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED									
Pennsylvania										USA										<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED									
9. COUNTY OF DEATH										6. AGE (In years last birthday)										7 UNDER 1 YEAR 8 UNDER 24 HRS									
Montgomery										51 YRS										MONTHS DAYS HOURS MIN									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)									
Bethesda										Naval Hospital										U. S. Navy - Retired									
12b. KIND OF BUSINESS OR INDUSTRY										13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY									
										Maryland										Montgomery									
13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER									
Chevy Chase										YES <input type="checkbox"/> NO <input type="checkbox"/>										5212 Saratoga Avenue									
14. FATHER'S NAME										15. MOTHER'S M A D E N NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?									
First Middle Last										First Middle Last										Yes (If yes give war or dates of service)									
Richard Benjamin Cochran										Nona Hessler										WWII, Korea									
16b. SOCIAL SECURITY NO										17. INFORMANT										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
217-36-9568										Mrs. Mary Townsend Cochran, 5212 Saratoga										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Colon with wide spread metastasis</b> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
1538																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?									
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										21a. ACCIDENT WAS UNDERLYING										21b. TIME OF INJURY									
Yes										<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										HOUR AM Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)									
										While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (this hospital) attended the deceased from Dec. 10, 1968, to Dec. 15, 1968, that (we) last saw the deceased alive on Dec. 15, 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.										22b. SIGNATURE										22c. DATE SIGNED									
										F. D. Keenan, Jr. MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										16 December 1968									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS										23a. BURIAL CREMATION. REMOVAL (Specify)									
F. D. Keenan, Jr., LCDR MC USN										Naval Hospital, Bethesda, Md.										Burial									
23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
12-18-1968										Arlington National Cemetery Arlington Va.																			
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Joseph Gawler Sons										5130 Wisconsin Ave., N.W., Washington, D.C.										DEC 20 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR
ABE			(NMI) COHEN			Dec. Month 26 Day 1968 Year			2:00PM
3. SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7 UNDER 1 YEAR
Male		Cauc.		Dec. 6, 1877			91 YRS		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Silver Spring			9039 Sligo Creek Pkwy			Ret. Merchant			Variety store
13a USUAL RESIDENCE (Where deceased was, if institution, Res. dence before admission) - STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland			Montgomery			Sil. Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9039 Sligo Creek Pkwy.
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Marcus			Cohen			Minnie Bush			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address
No			229-60-7569			Mrs. William Warsaw			Item #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial INFARCTION</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>coronary atherosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 10</u> , 19 <u>68</u> , to <u>present</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Francis Chuckler MD									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
FRANCIS CHUCKLER MD			2500 CALVERT ST NW WASH, DC						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/29/68		King David Cem		Falls Church Fairfax Va.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Jos. Gawler's Sons			5130 Wisc. Ave N.W. Washington, D.C.			JAN 2 1969		Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

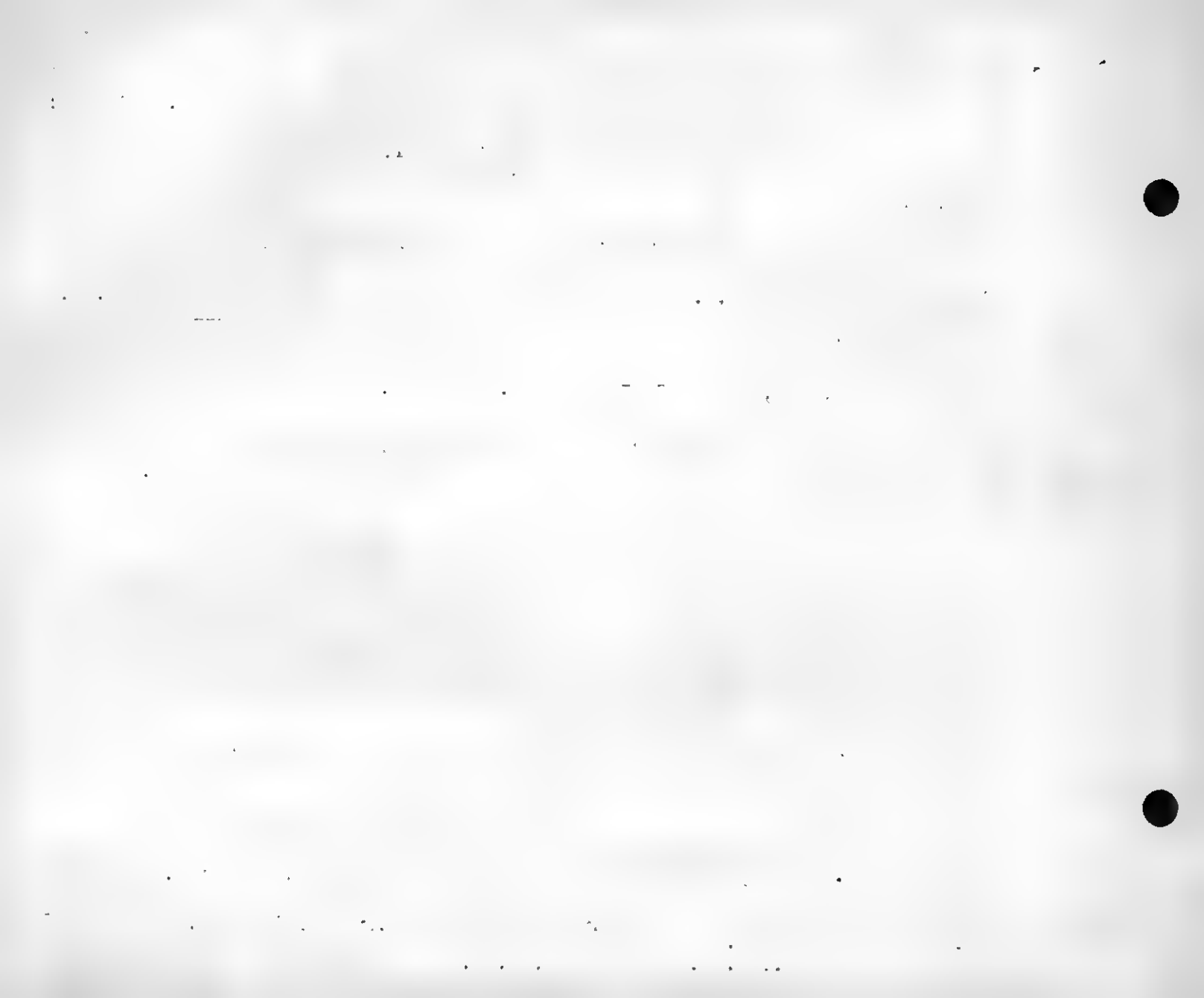
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

17720

17741

1 DECEASED-NAME (Type or print) <b>Leo Otis COLBERT</b>			2a. DATE OF DEATH <b>December 23, 1968</b> <b>mid night</b>		
3. SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>December 31, 1883</b>	
7a BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of work week (if ever retired)) <b>Coastal Geodetic Survey</b>	
13a USUAL RESIDENCE (Where deceased lived, if instituton. Residence before admission) - STATE <b>District of Columbia D.C.</b>		13b CITY OR TOWN <b>Washington DC</b>		13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME First Middle Last <b>Patrick --- Colbert</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Byrnes</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>Yes WWI, WWII, Kor</b>		16b SOCIAL SECURITY NO <b>577-48-3112</b>		17 INFORMANT <b>Daughter</b> <b>Mrs. Jeanne C. Doonan, Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma involving Stomach, Rectum and Prostate.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <del>to</del> (this hospital) attended the deceased from <b>December 16, 1968</b> , to <b>December 23, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 23, 1968</b> , and that in <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>to</del> (we) (did) (do not) view the body after death.					
22b. SIGNATURE 				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>E. PERLIN, LCDR MC USN</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		24. <b>Joseph Gawler &amp; Sons, Funeral Home</b> <b>5130 Wisconsin Ave., N. W. Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>	
25b. REGISTRAR'S SIGNATURE 					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17721

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17742

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Gerhard (none) Colm			2a. DATE OF DEATH Month Day Year December 25 1968		2b. HOUR P 3:25 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 30 June 1897		6. AGE (In years lost birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Germany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Economist		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3507 Hamlet Place	
14. FATHER'S NAME First Middle Last Emil Colm		15. MOTHER'S MAIDEN NAME First Middle Last Olga Strassburger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 579-44-1241	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia and genitourinary sepsis</u> 203X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 6 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>Dec. 20</u> , 1968, to <u>Dec. 25</u> , 1968, that (X) (we) last saw the deceased alive on <u>25 December 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>David A. Bray, M.D.</u> DEGREE 22d. PHYSICIAN'S NAME (Type) David A. Bray, M. D.				22c. DATE SIGNED 26 December 1968 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL, OR OTHER Cremation		23b. DATE 12/28/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (City or Town) (County) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR 5130 Wisc. Ave. N.W. Wash. D.C. JOS. GAWLER SONS, INC.		25a. REC'D BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge	



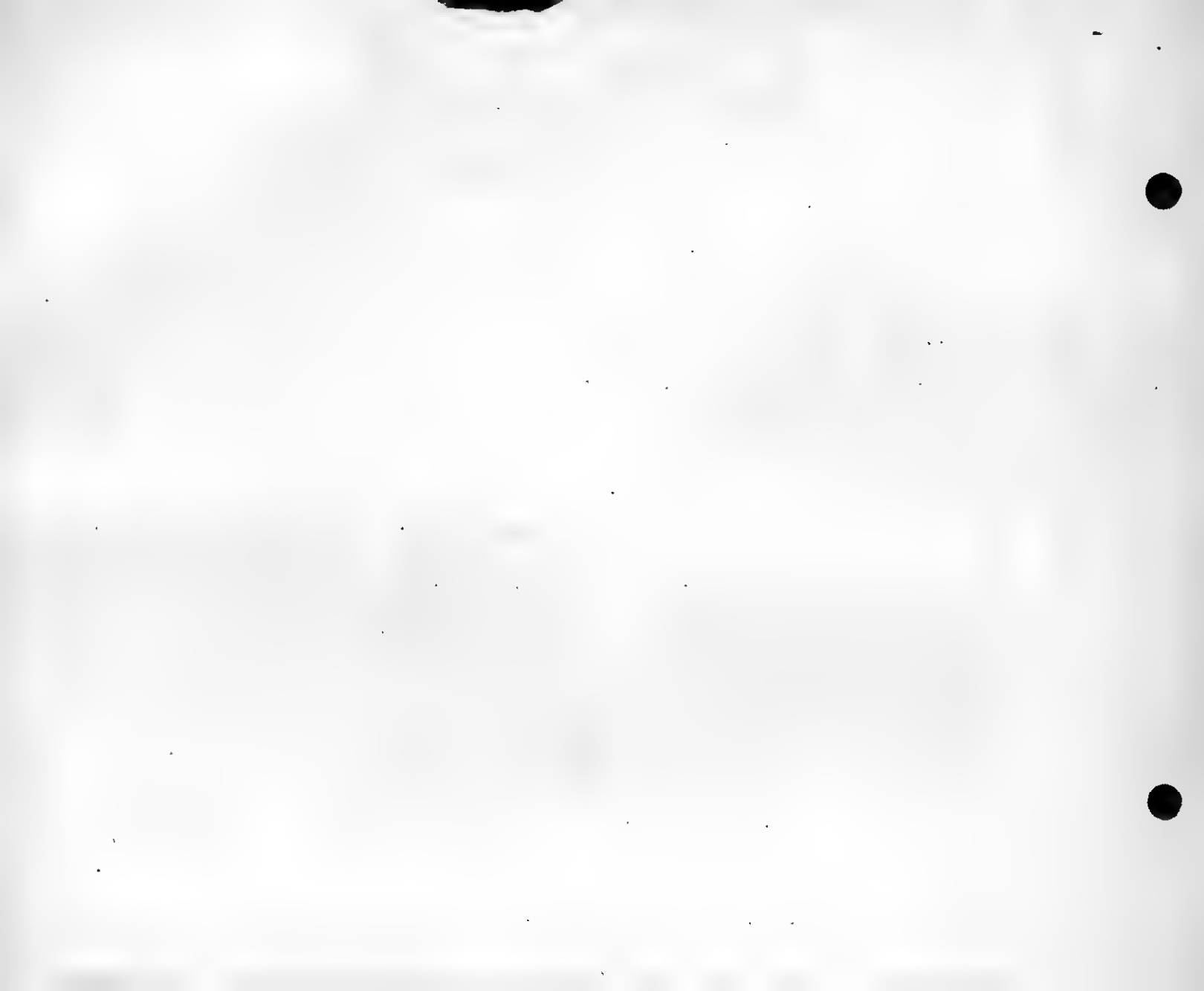
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 1 & Item 5 Film 408 1/2/69 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17743

1. DECEASED-NAME (Type or print) <b>May</b>		First <b>B</b>		Middle <b>B</b>		Last <b>Colton</b>		2a. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>11:55 PM</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>11/6/1889</b>				6 AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS <b>79</b> DAYS <b>79</b> HOURS <b>79</b> MIN		
7a BIRTHPLACE (State or foreign country) <b>San Antonio, Texas</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md						
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Chiley Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Nurse</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4503 Chestnut St Bethesda</b>				
14. FATHER'S NAME First <b>Andrew</b> Middle <b>Meyer</b> Last <b>Butler</b>		15. MOTHER'S MAIDEN NAME First <b>Lillian</b> Middle <b>Pringle</b> Last <b>Pringle</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. <b>358-10-4207</b>		17 INFORMANT <b>Barbara C Hughes</b>		Address <b>4503 Chestnut St Bethesda, MD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA, DORSAL SPINE, METASTATIC (BREAST)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA, R BREAST WITH RADICAL MASTECTOMY</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 Mo.</b> <b>1966</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARAPLEGIA AND CYSTITIS, URINARY</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>DEC 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>DEC 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Leo M. Curtis, M.D.</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>DEC. 19, 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>LEO M. CURTIS</b>		22e. ADDRESS <b>8218 WISCONSIN AVE. BETHESDA, MONT. MD.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Espc Ch</b>				23d. LOCATION (City or Town) (County) (State) <b>Sunderland Calvert Md</b>				
24. FUNERAL DIRECTOR <b>Robert A Pumphrey</b>		ADDRESS <b>7557 Wisconsin Ave Bethesda, Md</b>				25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

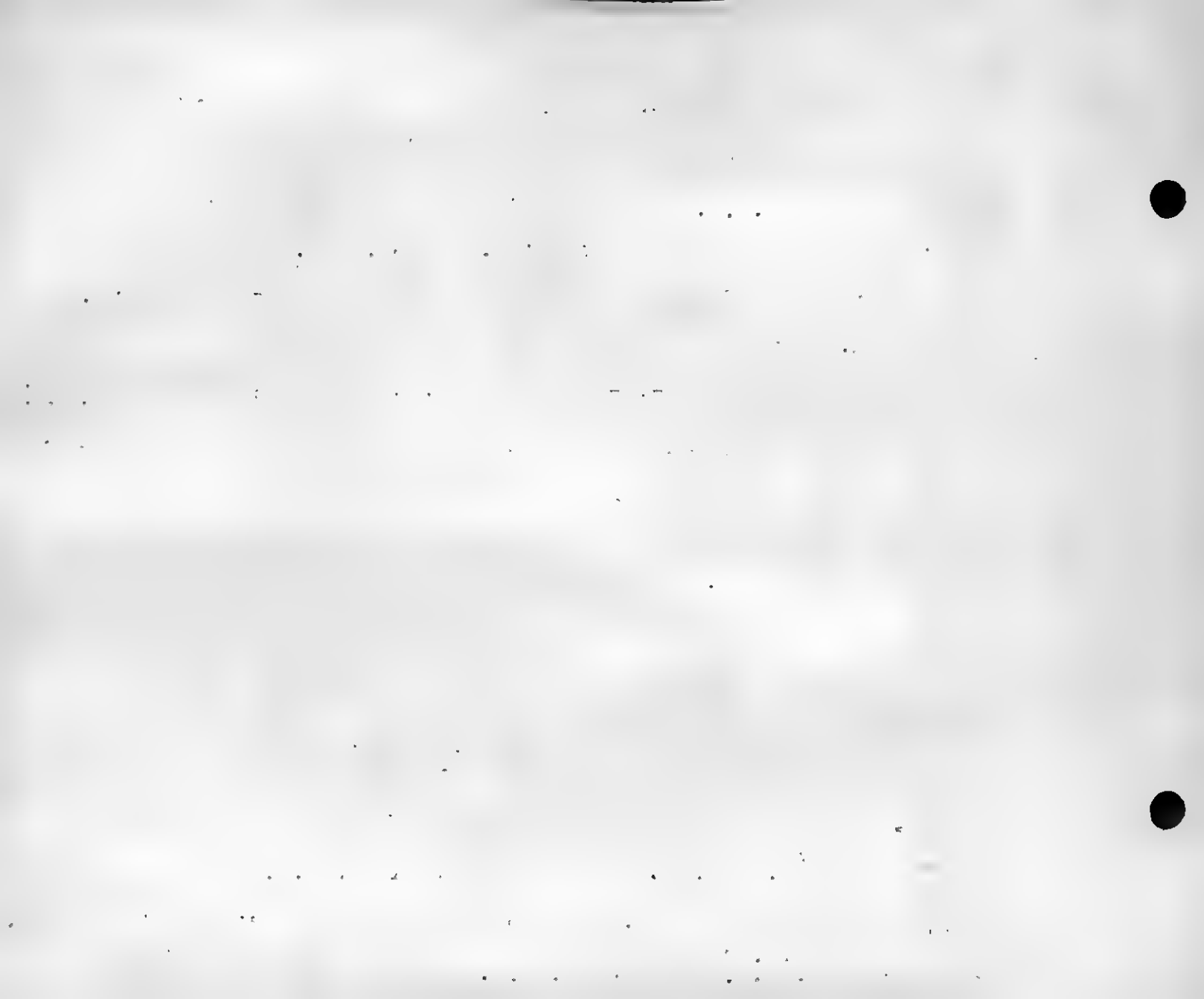
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR	
Marion Lee					Compton	Dec 3			6	34	6	34	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
M	W	April 13-1923	45 YRS	MONTHS		DAYS		Dec 3				6	34
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH					
D. C.		U. S. A.		WIDOWED		DIVORCED		Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Patomac			8501 Buckhannon Dr.			Accountant			Liberal				
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital, give street address)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET AND NUMBER				
Maryland			Montgomery			YES			8501 Buckhannon Dr.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Marion Lee Compton Sr.						Thelma Harrison							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
No						Leta L. Compton			Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Myocardial infarction, recent & old, left													
DUE TO, OR AS A CONSEQUENCE OF myocardium & septum													
(b) Coronary occlusion, right & left													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Severe coronary arteriosclerosis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
420													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH			HOUR A.M.										
			P.M.			19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									County				
									State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>						Dec 4, 1968				
John G Ball			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
			ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			12-7-68			Fairview Cemetery			West Hartford Conn.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Robert A Pumphrey			DEC 9 1968			f Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17704					17745				
1. DECEASED NAME (Type or print) First Middle Last <b>BERYL B. CONKLIN</b>					2a. DATE OF DEATH Month Day Year <b>12/ 21/ 1968</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6/28/90</b>		6. AGE (In years lost birthday) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>11503 Amherst Ave.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ret. Reg. Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. dence before admission) STATE <b>Md.</b>		13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>11503-Amherst Ave.</b>			
14. FATHER'S NAME First Middle Last <b>Francis B. Brown</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Alma Phelps Clark</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO <b>579-20-1701</b>		17. INFORMANT <b>Beryl C. Kester</b>		18. ADDRESS <b>1509 Constance St. Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Previous myocardial infarction Dec 1967</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>Dec 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>Oct 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) <del>did</del> (did not) view the body after death.									
22b. SIGNATURE <b>Edward J. Pacious MD</b>				22c. DATE SIGNED <b>12/21/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Edward J. Pacious</b>			
22e. ADDRESS <b>1746 K St. N.W.</b>				22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVA (Specify) <b>burial</b>		23b. DATE <b>12/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County, Md.</b>		23e. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>	
23f. ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		23g. REC'D BY REGISTRAR <b>DEC 26 1968</b>		23h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b H.O.B.	
William Judson COPELAND						Month Day Year		1968 955 P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
Male	Cauc.	27 Jun 1948	20 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	2d H.O.B.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Iowa		USA		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			Naval Cadet			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Iowa						Cedar Falls		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			1833 Grand Blvd.			
Willis Dale Copeland			Nora A. Caley						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
Yes			1967-1968			Mr. Willis Dale Copeland, 1833 Grand Blvd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <del>Pneumonia</del> Aspiration pneumonia, bilateral									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Subdural hematoma									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
-6-									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY?		
Dec 1, 1968			Subdural Hematoma				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			10:28 PM Nov 28 1968		Head injury playing football				
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
		Football field		Mural Academy		Annapolis			Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
John G. Ball			M.D.			12/5/68			
EXAMINER'S NAME (Type)			DEPT. TY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
John G. Ball, M. D.			DEPT. TY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a BURA, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			12-9-68		Memorial Gardens		Cedar Falls Iowa		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
W. W. Chambers Cow			DEC 9 1968			J. Charles Judge			
1400 Chapin Street, N. W. Washington, D.C.									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
DONALD			NMI CORNELL			Month Day Year		7:37 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	White	11-18-13	53 YRS.	MONTHS	DAYS	Month Day Year		7:37 AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
California, Pa.		U.S.A.				Montgomery Md.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring Md.			Holy Cross Hospital			teacher		education		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		114 East Church Street	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
Harvey --			Cornell			Elizabeth McDonald Cornell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT					
Yes			Yes		Anne Cornell (widow) California, Penna.					
					Caleffie Funeral Home Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary insufficiency;										
4121 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Severe arteriosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
420.										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
			Hour A.M. P.M.		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Belden R. Keap M.D.				22b. DATE SIGNED				
EXAMINER'S NAME (Type)		Belden R. Keap M.D.				DEC. 9, 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12-12-1968		Highland Cemetery		California Washington Pa.				
24. FUNERAL DIRECTOR		Carter Olsen Co.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				Sil. Spr. Md.		DATE DEC 12 1968		Richard J. Judy		
Warner E. Pumphrey, Inc. 8434 Georgia Avenue										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
17748										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
JOSEPH H			M. COVEY			December 31 1968		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)		IF UNDER 1 YEAR		
Male		White		Nov. 10, 1915		53 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			4821 Aspen Hill Road			X-Ray Tech.				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montg.		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4821 Aspen Hill	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Marion Covey			Bessie Aaron							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes			WWII		577-03-1368 Ellen C. Covey - wife- same item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, recent and remote									8 days	
DUE TO, OR AS A CONSEQUENCE OF										
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)									months	
(b) Coronary insufficiency										
DUE TO, OR AS A CONSEQUENCE OF									years	
(c) Severe Coronary arteriosclerosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Thrombosis Portal Vein, Post porta-caval shunt ( Post surg. 2 months)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1959, to 12/31, 1968, that (I) (we) lost saw the deceased alive on 12/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
STEPHEN N JONES							1/1/69			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					VIERS MILL ROAD - ROCK, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/3/69		Neelsville		Neelsville, Montg. Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tyson Wheeler Funeral Home		1331 Rockville Pike		JAN 6 1969		James Judge				
		Rockville, Md.								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Lulu</i>			First Middle Last <i>L Craft</i>			2a. DATE OF DEATH Month Day Year <i>12 29 68</i>		2b. HOUR <i>1:45 PM</i>	
3 SEX <i>FEMALE</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>10/10/03</i>		6. AGE (In years last birthday) <i>65</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>West VA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>Silver Spring</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1200 Lockwood Dr.</i>	
14. FATHER'S NAME First Middle Last <i>John M. Crone</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Chara M. Hunter</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Dorothy Hendrix Edgewater Md</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral infarction left hemisphere</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic Heart Disease - Chronic atrial fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4. pneumonia atelectasis left lung</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 18, 1968</i> , to <i>Dec 29, 1968</i> , that (I) <del>last</del> saw the deceased alive on <i>Dec 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) (did not) view the body after death.									
22b. SIGNATURE <i>Gene U. Cohen MD</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Dec 29, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen</i>				22e. ADDRESS <i>Silver Springs, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 2, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>End of the Trail Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>East Rainelle Greenbrier West Va.</i>			
24. FUNERAL DIRECTOR		F. Gasch's Sons		ADDRESS <i>Hyattsville, Md</i>		25a. REC'D BY REGISTRAR <i>JAN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Phillip</i>			First <i>Phillip</i>		Middle <i>--</i>		Last <i>Crossfield</i>		2a DATE OF DEATH Month <i>Dec.</i> Day <i>29</i> Year <i>1968</i>		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>2-26-1884</i>			6 AGE (in years last birthday) <i>84</i> YRS		2b. HOUR <i>11.30</i> AM		
7a BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md					
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8505 Springvale Road</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>you a printing office</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>you't.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Sil. Spr.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>8505 Springvale Rd.</i>		
14 FATHER'S NAME <i>Jahiel</i>			First <i>Jahiel</i>		Middle <i>--</i>		Last <i>Crossfield</i>		15. MOTHER'S MAIDEN NAME First <i>Cornelia</i> Middle <i>--</i> Last <i>Ellis</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>579-60-5319</i>		17. INFORMANT <i>Elberta A. Crossfield</i> Address <i>Sil. Spr. Md</i> <i>8505 Springvale Rd.</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart failure</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery heart disease</i> years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>60</i> , to <i>Dec 29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Dec 29</i> 19 <i>68</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert B. Drey</i>						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED <i>12-29-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert B. Drey</i>						22e ADDRESS <i>11161 New Hampshire Avenue, Sil. Spr., Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>1-2-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>						ADDRESS <i>Sil. Spr., Md</i>			25b REGISTRAR'S SIGNATURE <i>John C. Glen Carter</i>		
25a REGISTRAR'S SIGNATURE <i>John C. Glen Carter</i>						DATE <i>JAN 6 1969</i>			25c REGISTRAR'S SIGNATURE <i>John C. Glen Carter</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15  
45M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
177700									
17751									
1. DECEASED-NAME (Type or print) First Middle Last <b>Paul T. Culbertson</b>					2a. DATE OF DEATH Month Day Year <b>12-18-68</b>		2b. HOUR <b>7:40 P M</b>		
3 SEX <b>m</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>4/11/1897</b>		6 AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>MONTGOMERY</b> Md.			
10. CITY OR TOWN OF DEATH <b>DARNESTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RT. #28</b>			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>FOREIGN SERVICE - U.S. GOV'T.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>DARNESTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT. #28</b>	
4. FATHER'S NAME First Middle Last <b>GEORGE G. CULBERT</b>				5. MOTHER'S MAIDEN NAME First Middle Last <b>SARA SMITH</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO <b>W. W. I 577-56-1117</b>		17 INFORMANT Address <b>MARIA B. CULBERTSON - SAMEAS 13-E</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Glomerular Nephritis</b> <b>502X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5922</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)) <b>Chronic Brain Syndrome and Early Cirrhosis of Liver</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>67</b> , to <b>18 Dec</b> , 19 <b>68</b> , that (I) <del>was</del> last saw the deceased alive on <b>18 Dec</b> , 19 <b>68</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death									
22b. SIGNATURE <b>Gordon Murdoch Smith, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>19 Dec 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Gordon Murdoch Smith, MD</b>				22e. ADDRESS <b>Boyd's, Md 20720</b>					
23a. BURIAL OR CREMATION <b>XXXXXX</b>		23b. DATE <b>12-21-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Darnestown Md.</b>			
24 FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17752

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 3 25 AM		
Loyce			Enloe			Davis			Dec. 3 1968		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 4, 1887			6. AGE (n years last birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3802 Thornapple Street			12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired) Wife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Ch. Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3802 Thornapple		
14. FATHER'S NAME First Middle Last Isaac - Enloe			15. MOTHER'S MAIDEN NAME First Middle Last Rebecca -- Short								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 24-46-6400		17. INFORMANT Roy Josco Davis 3802 Thornapple Street						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) One of Arteriosclerosis 39-10 DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from August 2, 1943, to Dec 3, 1968, that (I) (we) last saw the deceased alive on Dec 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 12/3/68 3:25 AM											
22b. SIGNATURE William B. Wardrop M.D.			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12/3/68		
22d. PHYSICIAN'S NAME (Type) William B. Wardrop			22e. ADDRESS 808 Pershing Drive, Silver Spring, Md.								
23a. BURIAL, CREMATION REMOVAL (State) Burial			23b. DATE 12-6-1968		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24a. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue			ADDRESS Sil. Spr. Md.			25a. REC'D BY REGISTRAR DEC 3 1968			25b. REGISTRAR'S SIGNATURE [Signature]		



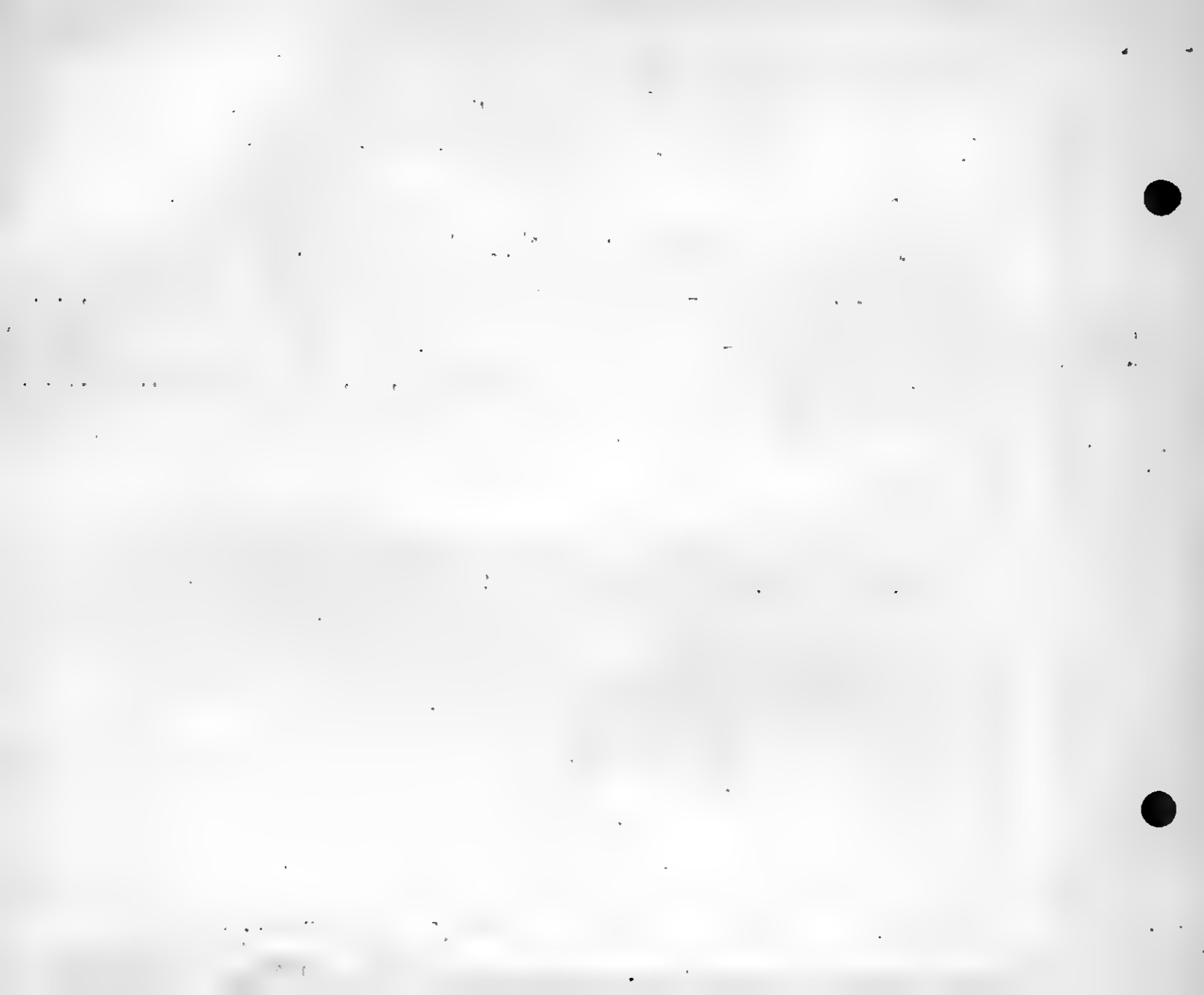
17753

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
RENÉE		T.	DAVIS	Month Day Year DEC 27 1968		8:30 A		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
FEMALE	WHITE		7/17/1887		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
California		U.S.A.		MONTGOMERY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		GROSVENOR LANE NURSING HOME		Homemaker		At Home		
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
D.C.		-----		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3900 Cathedral Ave., N.W.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT
First Middle Last		First Middle Last		Mary Rogers		Roger Davis, Son, 1621 Overlea Rd., Wash., D.C.		
Wilbur -- Tolson		Mary -- Rogers						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		BRONCHO PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
485X		DUE TO, OR AS A CONSEQUENCE OF				± 1 WK.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF				
491X		(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		CEREBRAL VASCULAR DISEASE - CHRONIC BRAIN SYNDROME						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BY <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 1946, to DEC 27, 1968, that (I) (we) last saw the deceased alive on DEC 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED				
		H. D. Ecker M.D.		12/27/68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
HENRY D. ECKER MD		916-19th ST. N.W. - WASH. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Cremation		12/30/68		Cedar Hill Crematory		Suitland, Maryland		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Joseph Gawler's Sons, 5130 Wis. Ave. NW, Wash., DC		JAN 2 1969		f Charles Judge				





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH  
2-14-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17753

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17754

1 DECEASED NAME (Type or Print)		First GLADYS		Middle JEAN		Last DAY		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 12-9- Year 19 68		2b HOUR M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 9/11/42		6 AGE (in years last birthday) 26 YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		2c DATE PRONOUNCED DEAD Month 12 Day 9 Year 19 68		2d HOUR 9:15p	
10 CITY OR TOWN OF DEATH Takoma Park				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b COUNTY P.G.		13c CITY OR TOWN Adelphi		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2402 Metzertott Rd.	
14 FATHER'S NAME First W. Middle Albert Last Wright				15 MOTHER'S MAIDEN NAME First Margaret Middle E. Last Clineman							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Family of Deceased				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound in head with cerebral laceration and exsanguination.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>laceration and exsanguination.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last.</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 981X				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year 9:00 P.M. 12-9 1968				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Deceased apparently shot in head by husband			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No City or Town County State 2402 Metzertott Rd. Adelphi Pr. Geo. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Deap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED Dec. 10, 1968			
EXAMINER'S NAME (Type) BELDEN R. DEAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Dec. 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Burrton Mary Michigan			
24 FUNERAL DIRECTOR J. Arthur Walters, 257 Carroll				ADDRESS BLANCK - LAC				25a. REC'D BY REGISTRAR DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17755											
1. DECEASED-NAME (Type or print) <i>Hortense</i> <i>HARRIS</i> <i>Degen</i>						2a. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>68</i>			2b. HOUR <i>7:35</i> AM		
3. SEX <i>Female</i>		4. RACE <i>Car.</i>		5. DATE OF BIRTH <i>April 11, 1914</i>			6. AGE (In years last birthday) <i>54</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Nsg. Home 1000 Daleview Dr</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>MD</i>			13b. COUNTY <i>Hudson</i>		13c. CITY OR TOWN <i>W. N.Y.</i>		13d. INSIDE CITY, IN 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6050 Kennedy Blvd. E.</i>		
14. FATHER'S NAME First <i>Leopold</i> Middle <i>HARRIS</i> Last <i>HARRIS</i>				15. MOTHER'S MAIDEN NAME First <i>Sadie</i> (Middle <i>(unknown)</i> Last <i>(unknown)</i> )							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give dates of service)				16b. SOCIAL SECURITY NO <i>051-01-7050</i>		17. INFORMANT Address <i>Eugenia Henn 570 N St., S.W., Wash., D.C.</i>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>multiple Metastasis Carcinoma</i> <i>174x</i> DUE TO, OR AS A CONSEQUENCE OF <i>Carcinoma Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>7 yrs.</i> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6+ wks.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>170x</i>											
19a. DATE OF OPERATION <i>170x</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <i>AM</i> Month <i>Dec</i> Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, garage, boarding, etc.) <i>at work</i>		21f. LOCATION. Street or R.F.D. No. <i>1100</i> City or Town <i>1968</i> County <i>16 Dec 1968</i> State <i>that (we) last saw the deceased alive on 15 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>11 Nov 1968</i> to <i>16 Dec 1968</i> , that (I) (we) last saw the deceased alive on <i>15 Dec 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE <i>W. H. Richwine MD</i>		22c. DATE SIGNED <i>1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>W. H. RICHWINE, MD.</i>		22e. ADDRESS <i>5222 Westview Ave Chevy Chase, Mont. MD.</i>		22f. DEGREE <i>MD</i>		22g. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION REMOVED (Specify) <i>Burial</i>		23b. DATE <i>12-19-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hungarian Union Fields Cem. Brooklyn, New York</i>				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc. 8434 Georgia Avenue</i>				24b. ADDRESS <i>Sil. Spr. Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Katherine Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

17715

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17756

1 DECEASED-NAME (Type or print) First Middle Last <b>BERTHA HENRIETTA DEMAR</b>			2a. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>68</u>		2b. HOUR <u>9:00</u> M.
3. SEX <b>FEMALE</b>		4 RACE <b>NEGROE</b>		5. DATE OF BIRTH <u>8-27-98</u>	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL</b>		9. COUNTY OF DEATH <b>MONTGOMERY</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>GAITHERSBURG</b>	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>Rt.#1</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED</b>	
14 FATHER'S NAME First Middle Last <b>JAMES STEWART</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNIE STEWART</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intra-Cranial Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>H.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1720</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>Dec 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Lack Schumacher</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>12-27-68</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>12-31-68</u>		<u>BROOKGROVE Cem.</u>	
23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR			
<u>Laytonsville Monty Md.</u>		<u>AN 3</u>			
24 FUNERAL DIRECTOR		25a. REGISTRAR'S SIGNATURE		25b REGISTRAR'S SIGNATURE	
<u>George R. Snowden</u>		<u>Rockville</u>		<u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

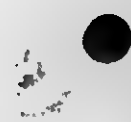
17736

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17757

1. DECEASED NAME (Type or Print) <i>Bartholomew A. Higgins</i>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>12 23 1968</i>			2b. HOUR <i>8:30 AM</i>	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>7-6-8-1908</i>	6 AGE (In years last birthday) <i>60 YRS</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <i>12 23 1968</i>	
7a. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		7b. CIT. ZEN. OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Montgomery</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>D.C.H. - SUBURBAN HOSP.</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>ATTORNEY</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>LAW</i>	
13a. USUAL RES. DENCE (Where deceased lived, if institution admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>DAVID FARRAGUT DIGGINS</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>MARGARET COLEMAN</i>		13e. STREET AND NUMBER <i>9716 W. Bethesda Rd</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>013-03-8668</i>		17 INFORMANT ADDRESS <i>Mona Higgins WIFE - SAME AS #13</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ex-Sanguine + 1017</i> DOE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Laceration of Jugular vein.</i> DOE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 1/2 HRS.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>7:25 PM 12/23/1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Cut Jugular Vein - Knife</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or RFD No City or Town County State <i>9716 W. Bethesda Rd Kensington Mont. Md</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Dec. 23, 1968</i>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Montg. Co., Md.</i>			
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/27/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Jos. Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C.</i>				<i>DEC 30 1968</i>		<i>J. Charles Judge</i>	



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

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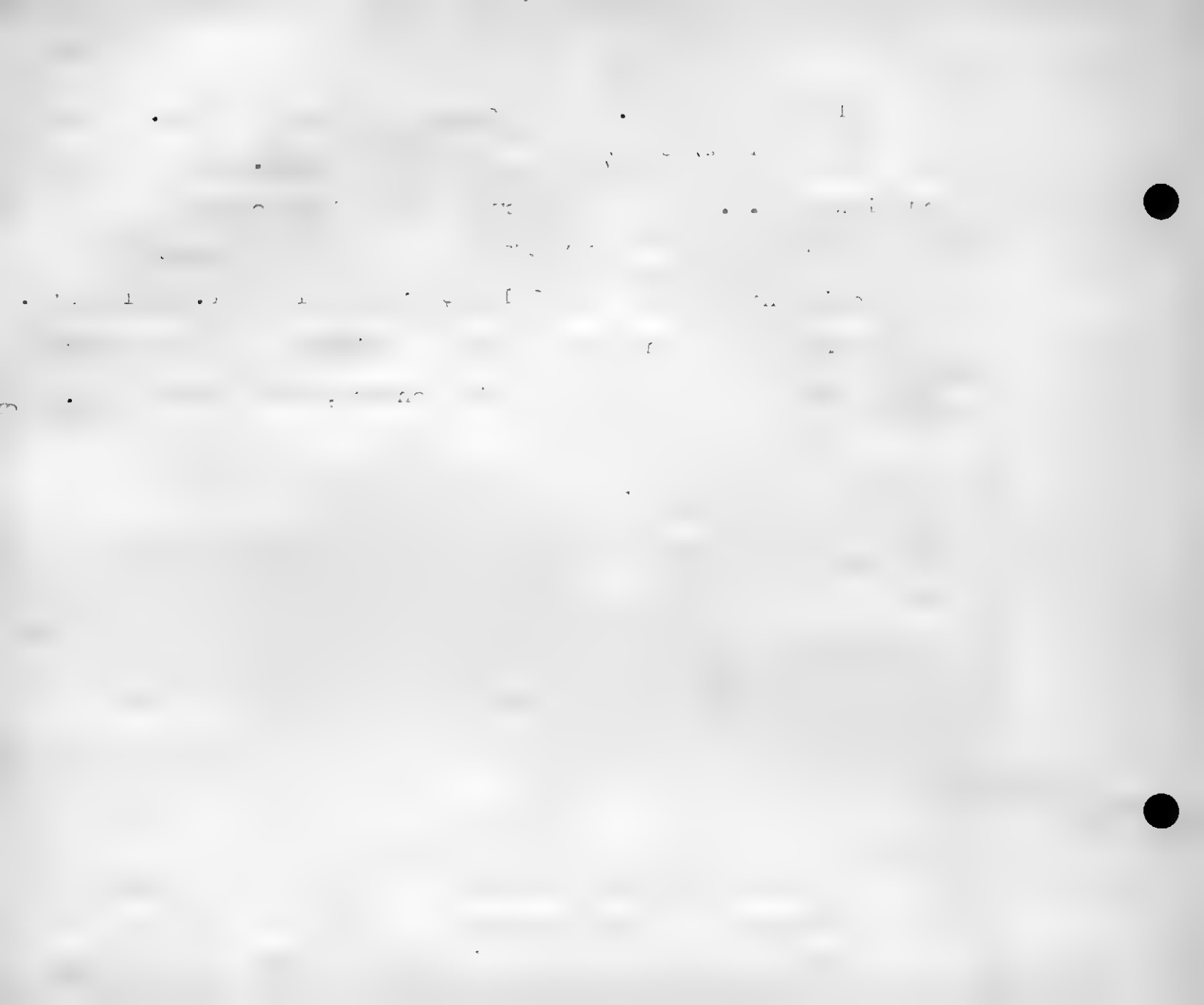
17737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17758

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR		
Alfred D. Donnaud						Dec. 25 1968			420 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
M	Cau	10/2/93	75 YRS					Dec. 25 1968			420 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Louisiana		U.S.				Montgomery					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross			Advertising - Retired					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Louisiana			New Orleans							1205 St. Charles Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Albert -- Donnaud			Siddie Siddie -- Dawkins								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
yes WWT			490-03-0485			John Donnaud, 11400 Lovejoy St.			Wheaton		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEC. 25, 1968			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			12-28-1968			Greenwood Cemetery			New Orleans Louisiana		
24 FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>Sil. Spr., Md.</u>						25a REC'D BY REG STRAR			25b REG STRAR'S SIGNATURE		
DATE <u>DEC 30 1968</u>						<u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 15-1  
30M REV 1-58

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17759											
1. DECEASED-NAME (Type or print) First Middle Last Edward Augusta Dove						2a. DATE OF DEATH Month Day Year Dec. 17 1968			2b. HOUR 5 PM		
3. SEX M		4. RACE W		5. DATE OF BIRTH April 23 1908		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12663-CHARLOTTA RD.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY AUTO.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12663-CHARLOTTA RD.			
14. FATHER'S NAME First Middle Last JAMES A. Dove		15. MOTHER'S MAIDEN NAME First Middle Last MONTGOMERY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 135		17. INFORMANT Family		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) EMPLOYMENT											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1956, 19 to 12/17/68, that (I) (we) last saw the deceased alive on 12/17/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John B. Umhau						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 12/17/68	
22d. PHYSICIAN'S NAME (Type) JOHN B. UMHAU						22e. ADDRESS 8805 Conn. Ave. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/20/68		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) (County) (State) Spring Hill					
24. FUNERAL DIRECTOR HANTON FUNERAL HOME - WASH. D.C.						25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE			



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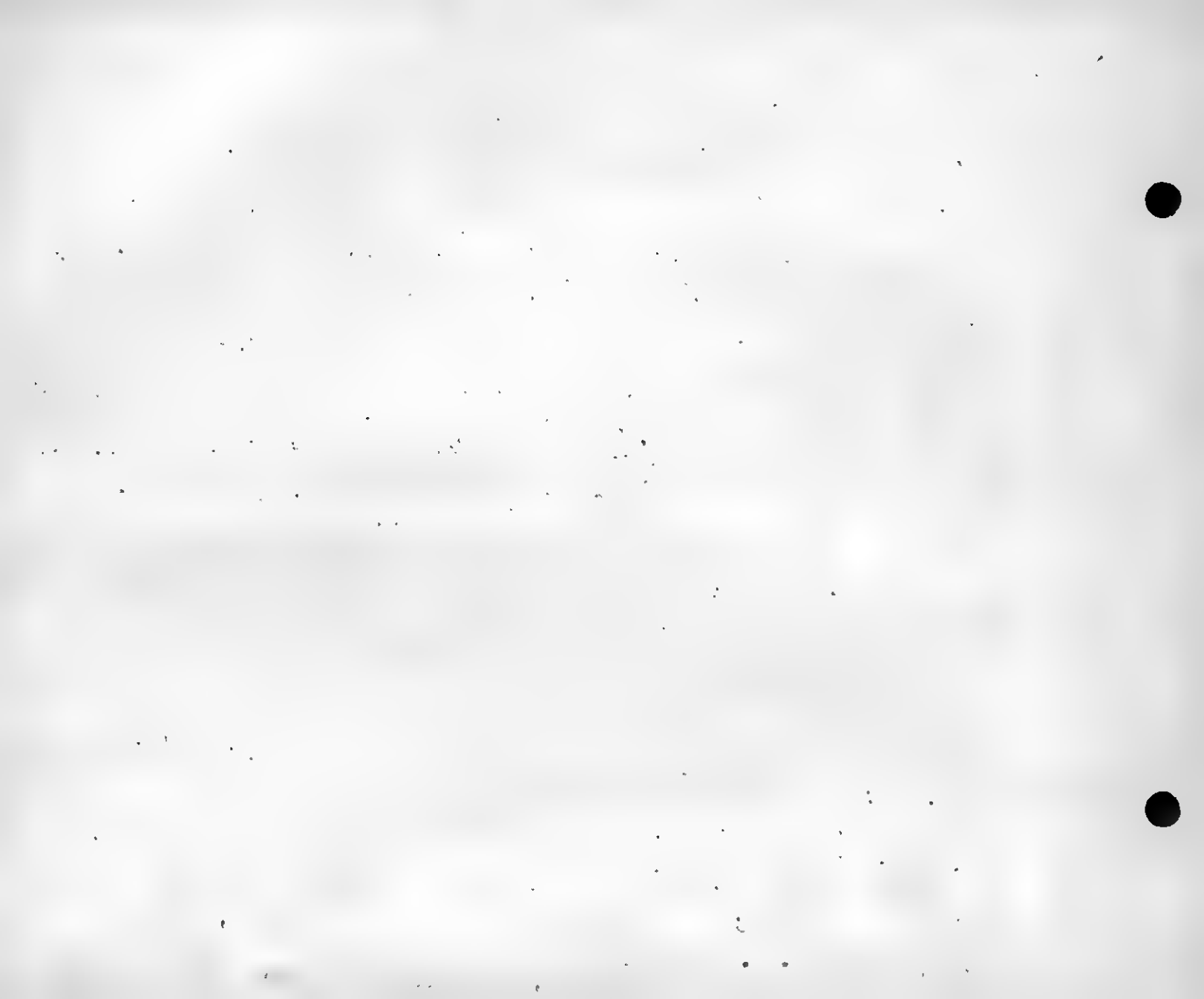
17719

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17760

1 DECEASED NAME (Type or print) <b>THOMAS C. DOWNES SR</b>			2a DATE OF DEATH Month <b>DEC</b> Day <b>30</b> Year <b>1968</b>			2b HOUR <b>6:15 A</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>JULY 6, 1902</b>		6 AGE (In years last birthday) <b>66</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>MONTGOMERY</b>	
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>WILLIAMS HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>BURIAL INSURANCE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>BURIAL</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MD</b>		13b COUNTY <b>MONTG.</b>		13c CITY OR TOWN <b>ROCKVILLE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>505 GILBERT PL.</b>		14 FATHER'S NAME First <b>OLIVER E.</b> Middle <b>BOWNES</b> Last <b>DOWNES</b>		15 MOTHER'S MAIDEN NAME First <b>JULIA</b> Middle <b>DULEY</b> Last <b>DOWNES</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b SOCIAL SECURITY NO <b>579-07-5001</b>		17 INFORMANT <b>THOMAS DOWNES JR.</b>		Address <b>807 CONNOR CT. ROCKVILLE, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>41</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few hours</b> <b>Several months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b> <b>None.</b>							
19a DATE OF OPERATION <b>None</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>None</b>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year <b>1968</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Sept.</b>			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>None</b>		21f LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a I certify that (I) (this hospital) attended the deceased from <b>Sept.</b> , 19 <b>68</b> , to <b>Dec 30</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 20</b> , 19 <b>68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
22b SIGNATURE <b>Lynwood Heiges M.D.</b>		22c DATE SIGNED <b>12/30/68</b>		22d PHYSICIAN'S NAME (Type) <b>LYNWOOD HEIGES</b>		22e ADDRESS <b>LYNWOOD HEIGES, M.D., F.M.C.A. 15015 Flower Valley Court Rockville, Maryland 20853</b>	
23a BURIAL, CREMATION, REMAINS (Specify) <b>Burial</b>		23b DATE <b>1/2/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Potomac</b>		23d LOCATION (Specify) <b>Potomac, Maryland</b>	
24 FUNERAL DIRECTOR <b>Tyson Wheeler F. H. 1331 Rockville Pike Rockville, Maryland</b>				25a REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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VR 406 (2)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First <b>Edward</b>	Middle <b>Harry</b>	Last <b>Drummer</b>	2a. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1968</b>		2b. HOUR <b>4:15 PM</b>	
3 SEX <b>Male</b>		4. RACE <b>Negro</b>		5 DATE OF BIRTH <b>9 July 1957</b>		6. AGE (In years last birthday) <b>11</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md.			
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Student</b>		12b KIND OF BUSINESS OR INDUSTRY <b>--</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Queen Annes</b>		13c CITY OR TOWN <b>Stevensville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>No street address</b>	
14. FATHER'S NAME First <b>Edward</b> Middle <b>Drummer</b> Last <b>Bordley</b>			15 MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>Bordley</b> Last <b>Bordley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis with bronchopneumonia, left upper lobe</b> <b>2040</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Lymphocytic Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2043</b> Pancreatic fat necrosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>2043 Pancreatic fat necrosis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (a) (this hospital) attended the deceased from <b>August 12, 1968</b> to <b>December 2, 1968</b> , that (b) (we) last saw the deceased alive on <b>December 2, 1968</b> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harmon J. Eyre MD</b>		22c. DATE SIGNED <b>3 December 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>Harmon J. Eyre, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BATTIS NECK</b>		23d. LOCATION (City or Town) (County) (State) <b>BATTIS NECK QUEEN ANNE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>BARBARA L. DASHIEN</b>		426 DOVER ST. <b>EASTON, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Young</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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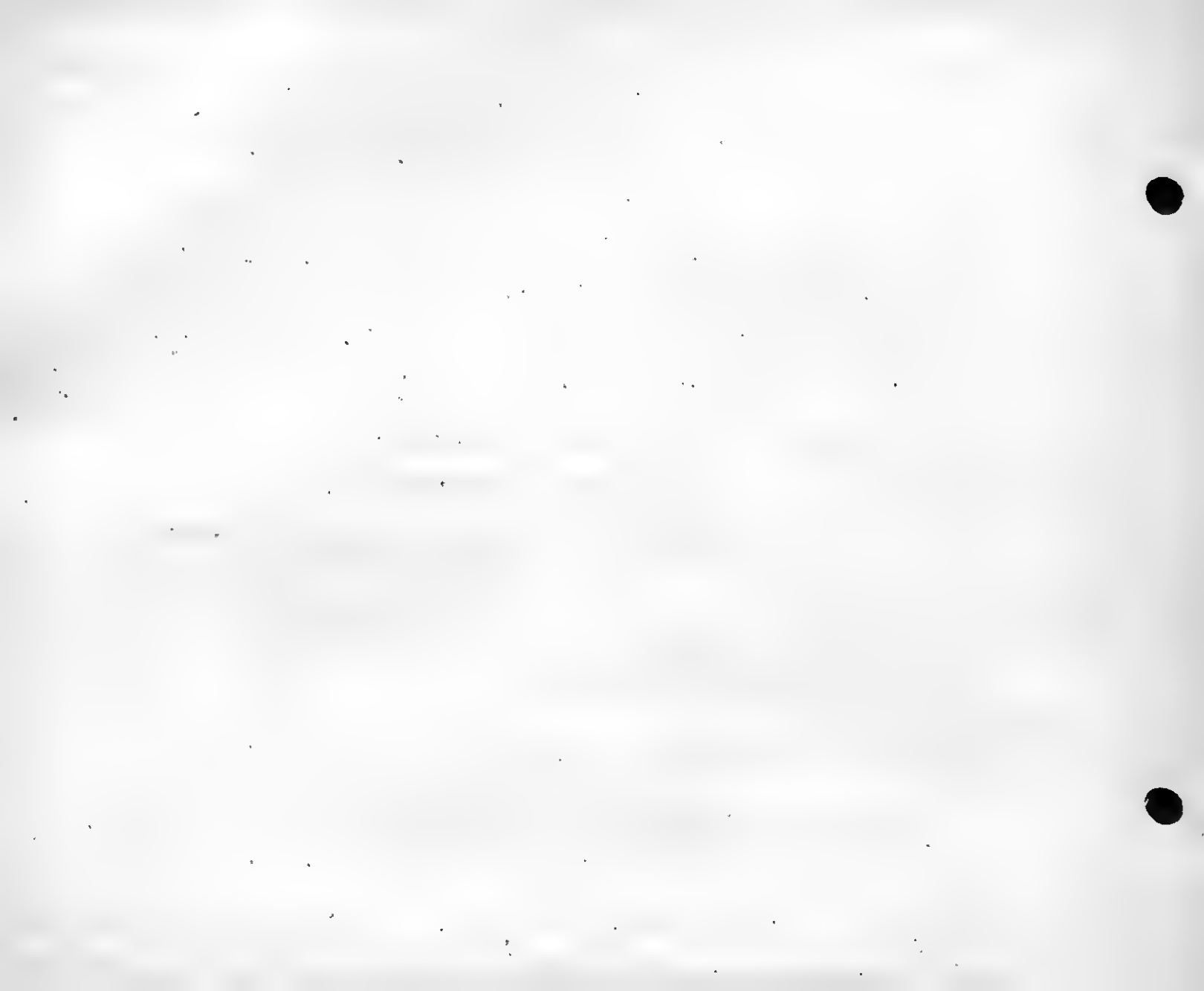
17751										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17762									
CERTIFICATE OF DEATH																													
1 DECEASED NAME (Type or print) <b>Bennie</b>					First <b>R.</b> Middle <b>ECHWALD</b> Last					2a DATE OF DEATH Month <b>December</b> Day <b>4</b> , Year <b>1968</b>					2b HOUR <b>745P</b>														
3 SEX <b>Female</b>					4. RACE <b>Caucasian</b>					5. DATE OF BIRTH <b>May 14, 1921</b>					6 AGE (in years last birthday) <b>47</b> YRS					IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>									
7a. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH <b>Montgomery</b> Md														
1d. CITY OR TOWN OF DEATH <b>Bethesda</b>					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>U. S. Naval Hospital</b>					12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Real Estate Saleswoman</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>					13b. COUNTY <b>Fairfax</b>					13c. CITY OR TOWN <b>Fairfax</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>3201 Sydenham Street</b>									
14 FATHER'S NAME <b>Unknown</b>					First <b></b> Middle <b></b> Last <b></b>					15 MOTHER'S MAIDEN NAME <b>Bennie Allen MILSTEAD</b>					First <b></b> Middle <b></b> Last <b></b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16b. SOCIAL SECURITY NO. <b>1440-12-2228</b>					17 INFORMANT <b>USAF LTCOL. Walter ECHWALD RET.</b>					Address <b>300 Army-Navy Dr. Arlington, Va.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast with widespread metastases</b>																													
DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b>																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION <b>170x</b>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>					21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>																			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 3, 1968</b> to <b>December 4, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 4, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death.																													
22b. SIGNATURE <b>D. L. Colgan</b>										DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>6 December 1968</b>														
22d. PHYSICIAN'S NAME (Type) <b>D. L. COLGAN M.D.</b>										22e. ADDRESS <b>U. S. NAVAL HOSPITAL, Bethesda, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>12-9-68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>														
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOME</b>										25a. REC'D BY REGISTRAR <b>DEC 9 1968</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>														
7557 Wisconsin Ave., Bethesda, Maryland																													



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Item 11-11-407 12/10/68 17752 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 <b>CERTIFICATE OF DEATH</b>										
1 DECEASED-NAME (Type or print)					2a DATE OF DEATH					
First Middle Last GEORGE M EDWARDS					Month Day Year DECEMBER 4 1968					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years lost birthday)		7a UNDER 1 YEAR MONTHS DAYS HOURS MIN		
M		W		OCT. 23 - 1896		72 YRS.				
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
POTOMAC MOUNT CO			U.S.A.				MONTGOMERY Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, when retired)			12b KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING			COLONIAL VILLA			CARPENTER (RETIRED)				
13a USUAL RESIDENCE (Where deceased lived, if institut. or Residence before admission) STATE					13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND					MONTGOMERY		SILVER SPRING		13e STREET AND NUMBER	
									11477 Old Columbia Pike	
14 FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
GEORGE W. EDWARDS					ELLA GRAY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b SOCIAL SECURITY NO.		17. INFORMANT			
NO					220-01-2029		Address 11477 Old Columbia Pike S.S.M.D. MILDRED A. EDWARDS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
12-7										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Aug 1963, to 12/4, 1968, that (I) (we) last saw the deceased alive on 12/3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
Joseph E. Smith, Jr.									12/4/68	
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
					Bartonsville, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
BURIAL			DECEMBER 7 1968		St. Andrews			Bartonsville, Maryland		
24 FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Arthur Kellers					254 Edward St.		DEC 9 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17753

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

17764

1 DECEASED NAME (Type or print) <b>Sarah</b>		First <b>Middle</b> <b>Last</b>	2a. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>68</b>		2b. HOUR <b>11:00 A.M.</b>
3 SEX <b>FEMALE</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>? 1893</b>	6 AGE (In years last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>RUMANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>TAKOMIA PARK</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH SAN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1001 Spring St. #622</b>	
14 FATHER'S NAME <b>ABRAHAM</b>	First <b>Middle</b> <b>Last</b>	15. MOTHER'S MAIDEN NAME <b>DAK VOORN</b>		First <b>Middle</b> <b>Last</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>578-28-5145</b>		17. INFORMANT <b>BENJETTLEMAN</b> Address <b>9224 BELLE DR NE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial Infarction</b> <b>Coronary Sclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6 hr.</b> <b>10 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4109</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>19</b> Year <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> hat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No <b>1219</b> City or Town <b>DR. Silver Spring, Md</b> County <b>Montgomery</b> State <b>Md</b>		
22a. I certify that (1) (this hospital) attended the deceased from <b>June 15, 1965</b> , to <b>12/9, 1968</b> , that (1) (we) last saw the deceased alive on <b>12/9, 1968</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Max G. Sherer MD</b>		DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>12/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>MAX G. SHERER</b>		22e. ADDRESS <b>800 Pershing Dr. Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/11/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D.C. Lodge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>WASH DC</b>		
24. FUNERAL DIRECTOR <b>Goodman Funeral Home</b>		ADDRESS <b>4217 9th Ave</b>	25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17765									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ROBERT			L. EVANS			Month Day Year			P
12/ 10 68			12:40						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Male		Cau.		4/4/96 1900		72 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Texas		U.S.A.				Montgomery Co. Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda, Maryland			Grosvenor Lane Nursing Home			Retired Broker			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Washington, D.C.			D.C.			Washington		13e. STREET AND NUMBER	
								1300 Somerset Pl., N.W.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Richard Evans			Adelia Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
Yes 4/20/18 3/17/19			577 50/ 7571						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation and aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma of mouth</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Syphilis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>144</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased, from <u>Nov 1968</u> to <u>Dec 10 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 7 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>David Burrows, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>9237 30th Silver Spring</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>12-14-68</u>		<u>Lincoln</u>		<u>Lincoln Md</u>					
24. FUNERAL DIRECTOR <u>Progen 389 B.I. one new work. etc.</u>		ADDRESS		25a. RECD BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				<u>DEC 16 1968</u>					





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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print)			First			Middle			Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 35 10 9 AM		
ROXXX ROXIE			P.			FARRAR						12 31 68					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
FEMALE			White			4/30/64			64 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						Md.		
VA.			USA						MONTGOMERY								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Silver Spring			HOLY CROSS														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
MONTGOMERY			MONTGOMERY			Rockville						13009 VANDALIA DRIVE					
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
Richard P. Dodd												Myrtle ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address					
No						230-20-2220			Henry T. Farrar			-Item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)												Septicemia					
DUE TO, OR AS A CONSEQUENCE OF												Hemorrhage					
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Pneumonia					
DUE TO, OR AS A CONSEQUENCE OF												2 days					
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
MEDICAL CERTIFICATION																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
			P.M. 19														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/24, 1968, to 12/31, 1968, that (I) (we) last saw the deceased alive on 12/30/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Francis Richmond			12/31/68			Francis Richmond			11412 Veirs Mill Road Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial-transit			1/4/69			Hebron Baptist			Avon, Virginia								
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Tyson Wheeler Funeral Home-1551 Rockville Pike			JAN 6 1969			James Judge											
Rockville, Maryland																	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>MARY</i>			First <i>D</i> Middle <i>Finch</i> Last			2a. DATE OF DEATH Month <i>Dec</i> Day <i>2</i> Year <i>1968</i>			2b. HOUR <i>8:45 A.M.</i>
3 SEX <i>female</i>		4 RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>5-21-1881</i>		6 AGE (In years last birthday) <i>87</i> YRS.		7 UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>12</i>	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md			
10 CITY OR TOWN OF DEATH <i>Kensington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens N.H.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>At home</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chevy Chase</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3601 Husted Drive</i>
14 FATHER'S NAME First <i>Joshua</i> Middle <i>Deans</i> Last			15 MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Eliza</i> Last <i>Vick</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>-</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <i>-</i>			17 INFORMANT Address <i>Chase, Maryland</i> <i>F. Irvin Finch, Sons, 3601 Husted Dr., Chevy</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>4</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>myocardial infarction &amp; decompensated heart</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive heart disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>2 months.</i> <i>12 years</i>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized Arteriosclerosis &amp; psychosis - Decubitus Ulcers.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>12</i> Day <i>4</i> Year <i>1968</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/27</i> , 19 <i>61</i> , to <i>12/2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/20</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Sherman A Thomas</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/2/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Sherman A Thomas</i>				22e. ADDRESS <i>4301 48th St N.W. Wash. D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Removal</i>		23b. DATE <i>12-4-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maplewood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Wilson, North Carolina</i>			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>				ADDRESS <i>5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Young</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
RHODA			MYRTLE	FINK	12 2 68		10:55 AM			
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		Feb. 5, 1895		73 YRS.		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. VA.		U.S.A.				Montgomery				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park			WASH. SAN. Hosp.			Counselor		Ch. Receiving		
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery		W. Hyatts		YES		1800 Drexel St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
ISRAEL			Getz	JANE					Sites	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
NO			216-46-7776		Carlton Fink		8303 26th Place, Adelphi		Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis									6 mo.	
DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma									3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
1621										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to Dec 1, 1968, that (I) (we) last saw the deceased alive on Dec 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Robert B. Iray						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 12-2-68		
22d PHYSICIAN'S NAME (Type) ROBERT B. IRAY						22e ADDRESS 11161 New Hampshire Ave. S.S.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		12-4-1968		St. Luke Lutheran Cemetery		Derwood Montgomery		Md.		
24. FUNERAL DIRECTOR M. Andrew Duwall Warner E. Pumphrey, Inc.						25a REC'D BY REG. STRAR DEC 6 1968		25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print) <b>PAULINE</b>			First Middle Last			2a DATE OF DEATH Month Day Year <b>Dec 20 1968</b>			2b HOUR <b>12:00 PM</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>6/18/55</b>			6 AGE (In years last birthday) <b>13 YRS</b>		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>			Md	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>S. P. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>				13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Bethesda</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>9921 Richard Drive</b>			
14 FATHER'S NAME First Middle Last <b>MORRIS RICHARDS</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>ROSE</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address <b>RICHARD FINKELSON</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, lungs</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1627</b>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 9, 1968</b> to <b>Dec 20, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 20, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Richard H. Pollen MD</b>						22c. DATE SIGNED <b>12/20/68</b>			22d PHYSICIAN'S NAME (Type) <b>RICHARD H. POLLEN MD</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>			23b DATE <b>23 Dec 68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>				
24. FUNERAL DIRECTOR <b>Joseph Gawlers Sons</b> ADDRESS <b>5130 Wisc. Ave. N. W. Wash D. C.</b>						25a REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MEDICAL CERTIFICATION

10



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17759

CERTIFICATE OF DEATH

17770

1. DECEASED-NAME (Type or print) <b>YETTA</b>			First Middle Last			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR <b>1:30 PM</b>		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>6-15-1894</b>			6. AGE (in years last birthday) <b>77</b> YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>University Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>WASH - D.C.</b>			13b. COUNTY			13c. CITY OR TOWN <b>D.C.</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>1336 Missouri Ave. N.W.</b>			14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>DRECH</b> Last <b>Leah</b>			15. MOTHER'S MAIDEN NAME First <b>Leah</b> Middle <b>Leah</b> Last <b>Leah</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Nathan Fishkin</b>			Address <b>1336 Missouri Ave. N.W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Probably Influenza</b> (b) <b>Probably Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Probably Influenza</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Dissecting Aortic Aneurysm, Congestive Heart Failure</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>12/31/68</b> to <b>12/31/68</b> , that (I) (we) last saw the deceased alive on <b>12/31/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel Dessoiff M.D.</b>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>12/31/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>SAMUEL D. DESSOFF</b>			22e. ADDRESS <b>1302-18th St. N.W. Wash. D.C.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Jan. 2, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ohev Shalom-Talmud Torah</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Bernard Danzonsky &amp; Sons</b>			ADDRESS <b>3501-14th St. N.W. Washington, D.C.</b>			25a. RECEIVED BY REGISTRAR <b>JAN 6 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>		



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177750										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
177750										177751									
1 DECEASED-NAME (Type or print) <b>Emma</b>					First <b>-</b> Middle <b>-</b> Last <b>Fitch</b>					2a DATE OF DEATH Month <b>DECEMBER</b> Day <b>22</b> Year <b>1968</b>					2b HOUR <b>9:23 P M</b>				
3 SEX <b>FEMALE</b>			4 RACE <b>CAUC.</b>			5 DATE OF BIRTH <b>7/1/1882</b>			6 AGE (In years last birthday) <b>86</b> YRS			IF UNDER 1 YEAR MONTHS <b>-</b> DAYS <b>-</b>			IF UNDER 24 HRS HOURS <b>-</b> MIN <b>-</b>				
7a BIRTHPLACE (State or foreign country) <b>CANADA</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>MONTGOMERY</b>					MD					
10 CITY OR TOWN OF DEATH <b>SILVER SPRING, MD.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>Althea Woodland Nursing Home 1000 BAYVIEW DRIVE - S. SPRING</b>			12a USAL OCCUPATION (Kind at work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b KIND OF BUSINESS OR INDUSTRY										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D.C.</b>			13b COUNTY <b>WASHINGTON</b>			13c CITY OR TOWN <b>WASHINGTON</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>2500 Q ST. N.W.</b>							
14 FATHER'S NAME First <b>SIGURTHUR</b> Middle <b>-</b> Last <b>GOODMAN</b>					15 MOTHER'S MAIDEN NAME First <b>SIGURLAUG</b> Middle <b>GUNNA</b> Last <b>DOTTIR</b>														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b SOCIAL SECURITY NO <b>577-68-699</b>			17 INFORMANT Address <b>MISS EVELYN FITCH, DAUGHTER, SAME AS #13</b>													
18 CAUSE OF DEATH (Enter any one cause per line for (a) (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Artery thrombosis</b>															<b>6 days</b>				
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b>															<b>5 years</b>				
DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>552X</b>																			
19a DATE OF OPERATION <b>-</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>										
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. <b>-</b> Month <b>-</b> Day <b>-</b> Year <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>-</b>													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. <b>-</b>			21f LOCATION Street or R.F.D. No. <b>-</b> City or Town <b>-</b> County <b>-</b> State <b>-</b>													
22a I certify that (I) (this hospital) attended the deceased from <b>Jan 29, 1959</b> , to <b>Dec 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b SIGNATURE <b>Frank S. Bacon M.D.</b>					DEGREE <b>PHYS</b> ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS <input type="checkbox"/>					22c DATE SIGNED <b>Dec. 23, 1968</b>									
22d PHYSICIAN'S NAME (Type) <b>FRANK S. BACON, M.D.</b>					22e ADDRESS <b>2141 - K-Street N.W.</b>														
23a BURIAL, CREMATION REMOVAL (Specify) <b>Removal-Burial</b>			23b DATE <b>12-24-1968</b>			23c NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Winnepeg, Manitoba, Canada</b>										
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>																			
25a REC'D BY REGISTRAR <b>DEC 27 1968</b>										25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



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MEDICAL EXAMINER NOTIFIED AND APPROVES

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
17772																							
1. DECEASED-NAME (Type or print)			First Agnes			Middle Marion			Last Foreman			2a. DATE OF DEATH Month 16			Day 26			Year 1968			2b. HOUR 6:30 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 11-13-08			6. AGE (In years last birthday) 26			YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md														
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. COUNTY PRINCE GEORGES			13c. CITY OR TOWN Ierisdale			13d. HOUSE CITY LHM 157 YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2259 Hannon St.											
14. FATHER'S NAME First Middle Last			SIMMONS			15. MOTHER'S MAIDEN NAME First Middle Last			BOLAND XXXXXXXX														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 577-07-2583			17. INFORMANT Son's daughter Address																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH: WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS, A CONSEQUENCE OF (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC VASCULAR DIS.</u> DUE TO, OR AS, A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>443X</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>63</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Bernard A. Fitzgerald MD</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12-16-68														
22d. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>			22e. ADDRESS <u>217 UNIV. BLVD. E., SILVER SPRING, MD.</u>																				
23a. BURIAL, CREMATION (Type)			23b. DATE 12-19-68			23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY			23d. LOCATION (City or Town) (County) (State) WASHINGTON, D. C.														
24. FUNERAL DIRECTOR <u>COLLINS FUNERAL HOME</u> ADDRESS <u>72 Collins</u>										25a. REC'D BY REGISTRAR DATE <u>DEC 20 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>										
500 UNIV. BLVD. W. SILVER SPRING, MARYLAND.																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17773					17773				
1. DECEASED-NAME (Type or print) First Middle Last <b>Vida Ann Fortner</b>					2a. DATE OF DEATH 12 Month 12 Day 68 Year			2b. HOUR 649 M	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4-5-83</b>		6. AGE (In years last birthday) 85 YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>American U.S.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San + Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY - J.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2308 Erskine St.</b>	
14. FATHER'S NAME First Middle Last <b>Perry</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Bell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>NO N E</b>		17. INFORMANT <b>Mrs. Louise Riffe</b>		Address <b>2308 Erskine St. Hyattsville Md</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5007 Pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Post op blood sequestration for</b> DUE TO, OR AS A CONSEQUENCE OF <b>obstructed blood circulation</b> <b>10 days</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>5015 Uremia, Post-cancerous.</b>									
19a. DATE OF OPERATION <b>12/4/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Strangulated obstructions</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> , 19 <b>68</b> , to <b>12/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Norman H. Isaacson M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/13/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>NORMAN H. ISAACSON, M.D.</b>		22e. ADDRESS <b>SILVER SPRING, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORTNER CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BAILEYSVILLE, W. VIRG. IN A</b>			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS &amp; CO. RIVERDALE, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408 MARYLAND STATE DEPARTMENT OF HEALTH  
1-15-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17774

1. DECEASED-NAME (Type or Print) <b>Larry Douglas Fowler</b>		2a. DATE KNOWN OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1968</b>		2b. HOUR <b>0:45 P.M.</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>6-5-12</b>	6. AGE (In years just birthday) <b>55</b> YRS	7. IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Makam Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Georgetown on 21st St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Letter carrier</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>PR</b>		13c. CITY OR TOWN <b>Hyattsville</b>
14. FATHER'S NAME First <b>John</b> Middle <b>Fowler</b> Last <b>Fowler</b>		15. MOTHER'S MAIDEN NAME First <b>Ann</b> Middle <b>Town</b> Last <b>W. Hyattsville</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
16b. SOCIAL SECURITY NO. <b>254 18 1021</b>		17. INFORMANT <b>Mary B Fowler</b>		ADDRESS <b>W Hyattsville, Md.</b>
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive right subdural</b> <b>880X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hemorrhage and hematoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>9--</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. <b>12/25</b> P.M. <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased fell down basement stairs at home.</b>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>W. Hyattsville</b> City or Town <b>F.G.</b> County <b>MD</b> State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Belden R. Keap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>Dec. 26, 1968</b>
EXAMINER'S NAME (Type) <b>BELDEN R. KEAP M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City or town, or county) <b>Hyattsville</b>
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	23b. DATE <b>Dec 30, 1968</b>	23c. NAME OF CEMETERY OR CREMATOR <b>George Washington</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 31 1968</b>
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M 1/69

17784										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17775																								
CERTIFICATE OF DEATH																																												
1. DECEASED NAME (Type or print)					First <b>NELLIE</b>					Middle <b>LOUISE</b>					Last <b>FRAZIER</b>					2a. DATE OF DEATH					2b. HOUR																			
															<b>DECEMBER</b>					Month					Day <b>2</b> Year <b>68</b>					7:45 PM														
3. SEX <b>FEMALE</b>					4. RACE <b>CAUCASIAN</b>					5. DATE OF BIRTH <b>MARCH 31, 1934</b>					6. AGE (in years last birthday) <b>34</b> YRS					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					IF UNDER 24 HRS HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) <b>TEXAS</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>MONTGOMERY</b>										Md																			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>					11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>NAVAL HOSPITAL</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>																													
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>VIRGINIA</b>					13b. COUNTY					13c. CITY OR TOWN <b>QUANTICO</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>3502-B, MCB</b>																								
14. FATHER'S NAME					First <b>ION</b>					Middle <b>THOMAS</b>					Last <b>VOUGHAN</b>					15. MOTHER'S MAIDEN NAME					First <b>BIRTLE</b>					Middle <b>(UNKNOWN)</b>					Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>					(If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b>463-48-9024</b>					17. INFORMANT <b>ROBERT R. FRAZIER, 3502-B, MCB, QUANTICO, VA.</b>										Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hodgkin's disease involving lungs and right ovary</b>																																												
DUE TO, OR AS A CONSEQUENCE OF																																												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																												
DUE TO, OR AS A CONSEQUENCE OF																																												
(c)																																												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																												
19a. DATE OF OPERATION															19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)															21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work															21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (a) (this hospital) attended the deceased from <b>NOV. 23</b> , 19 <b>68</b> , to <b>DEC. 2</b> , 19 <b>68</b> , that (b) (we) last saw the deceased alive on <b>DEC. 2</b> , 19 <b>68</b> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (not) view the body after death.																																												
22b. SIGNATURE <b>John A. Routenberg MD</b>															DEGREE <b>MD</b>										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>4 December 1968</b>														
22d. PHYSICIAN'S NAME (Type) <b>John A. Routenberg, M. D.</b>															22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>															23b. DATE <b>12-7-68</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Chapel Wood Mem. Park</b>										23d. LOCATION (City or Town) (County) (State) <b>TEXAS</b>									
24. FUNERAL DIRECTOR <b>R.A. PUMPHREY FUNERAL HOME, 7557 WISCONSIN AV.</b>															25a. REC'D BY REG. STRAR <b>DEC 9 1968</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
Andrew Vansice-French						Month Day Year			12 3 1968	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR	
M.	W.	April 14, 1917	51 YRS	MONTHS	DAYS	Month Day Year			12 3 1968	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH	
New Jersey			U.S.A.			NEVER MARRIED			Montgomery	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Rockville			1617 Grunther Ave			Engineer			Gov.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
Md.			Montgomery			Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.	
Andrew Vansice French			Mella Holland			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			079-07-2273	
17. INFORMANT			18. ADDRESS			19. DATE SIGNED			20. DATE SIGNED	
Wife: Mary Jane French			Same as m			13			13	
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of Brain</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gun shot wound of Head</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
16c. <u>None</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)			22. DATE SIGNED	
9 12-3 1968			9 12-3 1968			Shot self in head 45 cal. Pistol			Dec 3, 1968	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
1617 Grunther Ave. Rockville Montgomery			None							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED			22c. DATE SIGNED			22d. DATE SIGNED	
Dec 3, 1968			Dec 3, 1968			Dec 3, 1968			Dec 3, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			12/6/68			Winchester National			Winchester, Virginia	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE	
Tyson Heeler 1331 Rockville Pike Rockville, Maryland			DEC 6 1968			J. J. Bell			J. J. Bell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

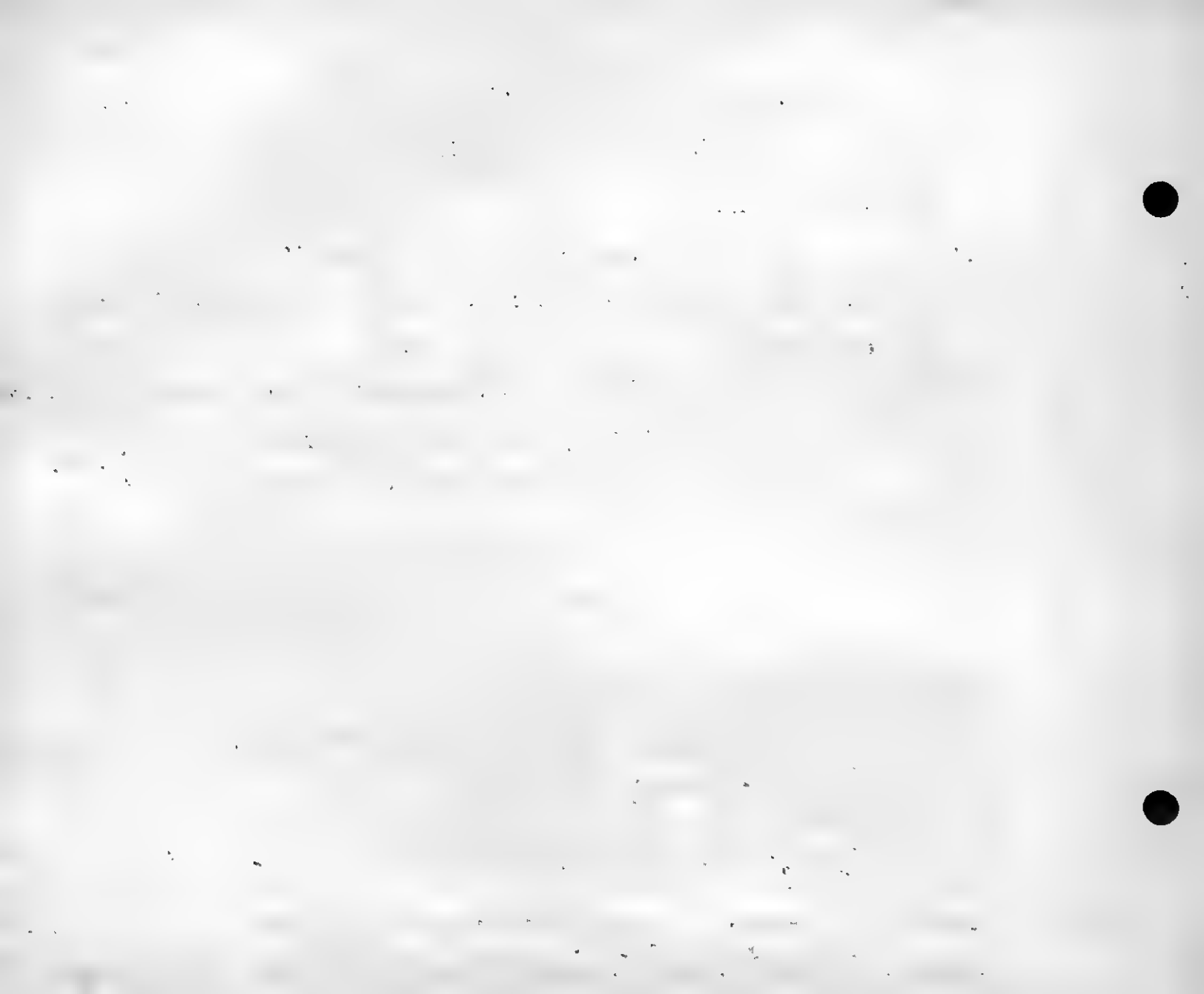
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17776

17777

1. DECEASED-NAME (Type or print) <b>ELEANOR</b>		First Middle Last		2a. DATE OF DEATH Month <b>Dec</b> Day <b>14</b> Year <b>1968</b>		2b. HOUR <b>4:00 PM</b>	
3. SEX <b>female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 6, 1923</b>		6. AGE (In years last birthday) <b>45</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>12,001 Uiers Mill Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spring</b>		13d. INSIDE CITY, Y.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>12,001 Uiers Mill Road</b>		14. FATHER'S NAME First Middle Last <b>Maurice Kramer</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mania unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (no, or unknown)		16b. SOCIAL SECURITY NO. <b>158-20-9139</b>		17. INFORMANT <b>Mr. Edward Frisch</b>		Address <b>12,001 Uiers Mill Rd. S.S. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA RT. BREAST</b> <b>174X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>WITH GENERALIZED METASTASIS</b> (c) <b>WITH GENERALIZED METASTASIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>170x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/19</b> , 19 <b>68</b> , to <b>12/14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David Goldenberg</b>		22c. DATE SIGNED <b>12/14/68</b>		22d. PHYSICIAN'S NAME (Type) <b>DR. DAVID GOLDENBERG</b>			
22e. ADDRESS <b>7801 GEORGETOWN, SILVER SPRING, MARYLAND</b>		22f. DEGREE <b>DEGREE</b>		22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		22h. MED. DIRECTOR <input type="checkbox"/>	
22i. STAFF PHYSICIAN <input type="checkbox"/>		22j. ADDRESS <b>7801 GEORGETOWN, SILVER SPRING, MARYLAND</b>		22k. DATE SIGNED <b>12/14/68</b>		22l. SIGNATURE <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Solomon Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Clifton N.J.</b>	
24. FUNERAL DIRECTOR <b>M. Andrew Duwall</b> <b>Warner E. Humphrey Inc. 8434 Ga. Avenue S.S.</b>				25a. REC'D BY REGISTRAR <b>DEC 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17778	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First Francis		Last Gahan		Middle 2.		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day 12-25 Year 1969		2b HOUR 5:30 P.M.	
3 SEX male	4 RACE white	5 DATE OF BIRTH 3-12-27		6 AGE (In years last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 12-25 Day Year 1969		2d HOUR 5:30 P.M.
7a BIRTHPLACE (State or foreign country) Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give Street Address) Sil. Spr.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b KIND OF BUSINESS OR INDUSTRY Navy Dept.			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spr.		3d INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 11200 Lockwood Dr.			
14. FATHER'S NAME First Middle Last John B. Gahan		15 MOTHER'S MAIDEN NAME First Middle Last Mary -- Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If not give year of dates of service) 577-60-3808		17 INFORMANT Centwine Gahan		ADDRESS 11200 Lockwood Dr. S.S., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>420.</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 25, 1968		ADDRESS (City, town, or county)	
EXAMINER'S NAME (Type) BELOEN R. REAP M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-30-1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		24. FUNERAL DIRECTOR J.W. Lee, Jr. Warner E. Pumphrey, Inc. 8434 Georgia Avenue	
25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA AIS 141  
15M - 1769

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
177768					177779				
1. DECEASED-NAME (Type or print) First <i>William</i> Middle <i>Kenneth</i> Last <i>Gallagher</i>					2a. DATE OF DEATH Month <i>Dec</i> Day <i>18</i> Year <i>1968</i>				
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>8/16/11</i>		6 AGE (In years last birthday) <i>57</i> YRS		7b. UNDER YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Much</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Postman</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY (Y/N) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>8402 Stonybrook Dr</i>	
14 FATHER'S NAME First <i>William J.</i> Middle <i>Gallagher</i> Last <i>Gallagher</i>		15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Mc Dougall</i> Last <i>Mc Dougall</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>					
16b. SOCIAL SECURITY NO <i>370-01-5054</i>		17 INFORMANT <i>Wife Doris Gallagher</i> Address <i>Same as above</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma, right kidney with diffuse wide-spread metastases</i>									<i>8 months</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>180x</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>1966</i> to <i>Dec 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 18, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James W. Egan MD</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <i>James W. Egan</i>		22e. ADDRESS <i>5413 Cedar Lane, Bethesda, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL <i>burial</i>		23b. DATE <i>Dec. 20, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alpena, Michigan</i>			
24. FUNERAL DIRECTOR <i>Pumphrey, Inc.</i>		24a. ADDRESS <i>8434 Georgia Avenue, Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
17780					17780							
1. DECEASED NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR		
CATHERINE					GALLO					2A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		9-23-1921			47 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
PATERSON N.J.		USA				MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
SILVERSPRING MD		HOME				AW						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
MD		MONTG.		SILVERSPRING				9904 COLESVILLE RD.				
14. FATHER'S NAME First Middle Last				15. MOTHER'S M.A.DEN. NAME First Middle Last								
THOMAS DE FEE				SARA BARBERA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address				
No		UNKNOWN		LOUIS GALLO, 13a, b, c, d above								
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1541 CARCINOMA RECTUM METASTATIC										1 and 6 mo		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
154X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE				22c. DATE SIGNED								
John O. Robben MD				11-4-1968								
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS								
John O. Robben M.D.				10400 CONNETT TAVENKENSINGTON MD								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
BURIAL		6 DEC. 1968		GATE of HEAVEN		SILVER SPRING MD.						
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
RINALDI FUNERAL HOME INC				DEC 26 1968				John O. Robben				



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>GALLOWAY ANN JOHNSTON GALLOWAY</b>						2a. DATE OF DEATH January Month Day Year <b>December 21 1968</b>			2b. HOUR <b>1:15 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>10/14/81</b>		6. AGE (In years last birthday) <b>87 YRS</b>		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Aberdeen, Scotland</b>		7b. CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md					
10. CITY OR TOWN OF DEATH <b>Silver Spring, Maryland</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Colonial Villa Nursing Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>2009 Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Aurville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2009 Hayden Road</b>	
14. FATHER'S NAME First Middle Last <b>Thomas -- Johnston</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Ann -- Dunbar</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>				16b. SOCIAL SECURITY NO. <b>0673 577-64-XXXX</b>		17. INFORMANT Address <b>Aurville, Md.</b> <b>Mrs. James A. Crawford 2009 Hayden Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal hypostatic pneumonia</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHD &amp; generalized debility</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8-10 days</b> <b>6 months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4124</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> to <b>12/21, 1968</b> , that (I) (we) last saw the deceased alive on <b>12/20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Hugh Grey, M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/21/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Hugh Grey, M.D.</b>						22e. ADDRESS <b>11161 New Hampshire Avenue, Sil. Spr. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2-23-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Maryland</b>					
24. FUNERAL DIRECTOR <b>W. Lee Judd</b> <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>						25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17772

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17783

1. DECEASED NAME (Type or Print) <i>Margaret Elizabeth Calkerson</i>			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <i>Jan 51 1968</i>			2b. HOUR <i>5:23</i>		
3 SEX <i>female</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>9/19/20</i>	6 AGE (in years last birthday) <i>48</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>Jan</i> Day <i>31</i> Year <i>1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>Montgomery, U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3308 - Longgate Ct.</i>
14. FATHER'S NAME First <i>Cornelius</i> Middle <i>McGuire</i> Last <i>McGuire</i>			15. MOTHER'S MAIDEN NAME First <i>Florence</i> Middle <i>Keough</i> Last <i>Keough</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		
16b. SOCIAL SECURITY NO <i>039-10-929</i>			17. INFORMANT <i>Cornelius McGuire</i>			ADDRESS <i>281 - Central Heights</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe -</i> <i>14.7</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Trauma from Impact of Auto.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sudden.</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>812+</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>4:45 P.M. Dec 31 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Stepped in front of Auto</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>			21f. LOCATION Street or R.F.D. No. City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md</i> <i>Corner Twinbrook Pk + Halpine Rd.</i>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Dec 31 1968</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)								
23a. BURIAL CREMATION <i>Burial</i>			23b. DATE <i>1/6/1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. St. Mary's Cemetery</i>		
23d. LOCATION (City or Town) <i>Pawtucket</i>			(County) <i>R. I.</i>			23e. STATE		
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>			ADDRESS <i>Rockville Pike</i>			25a. REC'D BY REGISTRAR <i>James J. Jones</i>		
DATE <i>JAN 6 1969</i>			25b. REGISTRAR'S SIGNATURE					

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1. The first of these is the fact that the system is not a simple one, and that the results are not always the same. The second is that the system is not a simple one, and that the results are not always the same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
TESSIE			GEUNSON			Month Day Year 12 31 68			6:38 PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
F	WHITE		5/20/99			69 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
POLAND			USA						MONTGOMERY Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING			HOLY CROSS			UNEMPLOYED			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY L. MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
D.C.			MONTG.			WASHINGTON			13e. STREET AND NUMBER
									1125 SPRING RD
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
BENJAMIN			WITT			DEENA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						Harry Witt 75W Maple Ave H.K. PK. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE BRONCHO PNEUMONIA.									DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE									WKS.
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE									YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFF CE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1968, to 12/31, 1968, that (I) (we) last saw the deceased alive on 12/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Albert H. Grollman						12/31/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
ALBERT H. GROLLMAN						1106 SPRING ST. SILVER SPRING			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
			1-2-69		OHEVSHOLOM TIKUD TORAH		WASHINGTON, D.C.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bernard Dancushy & Sons 3501-14th St N.W. Wash. D.C.						JAN 6 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

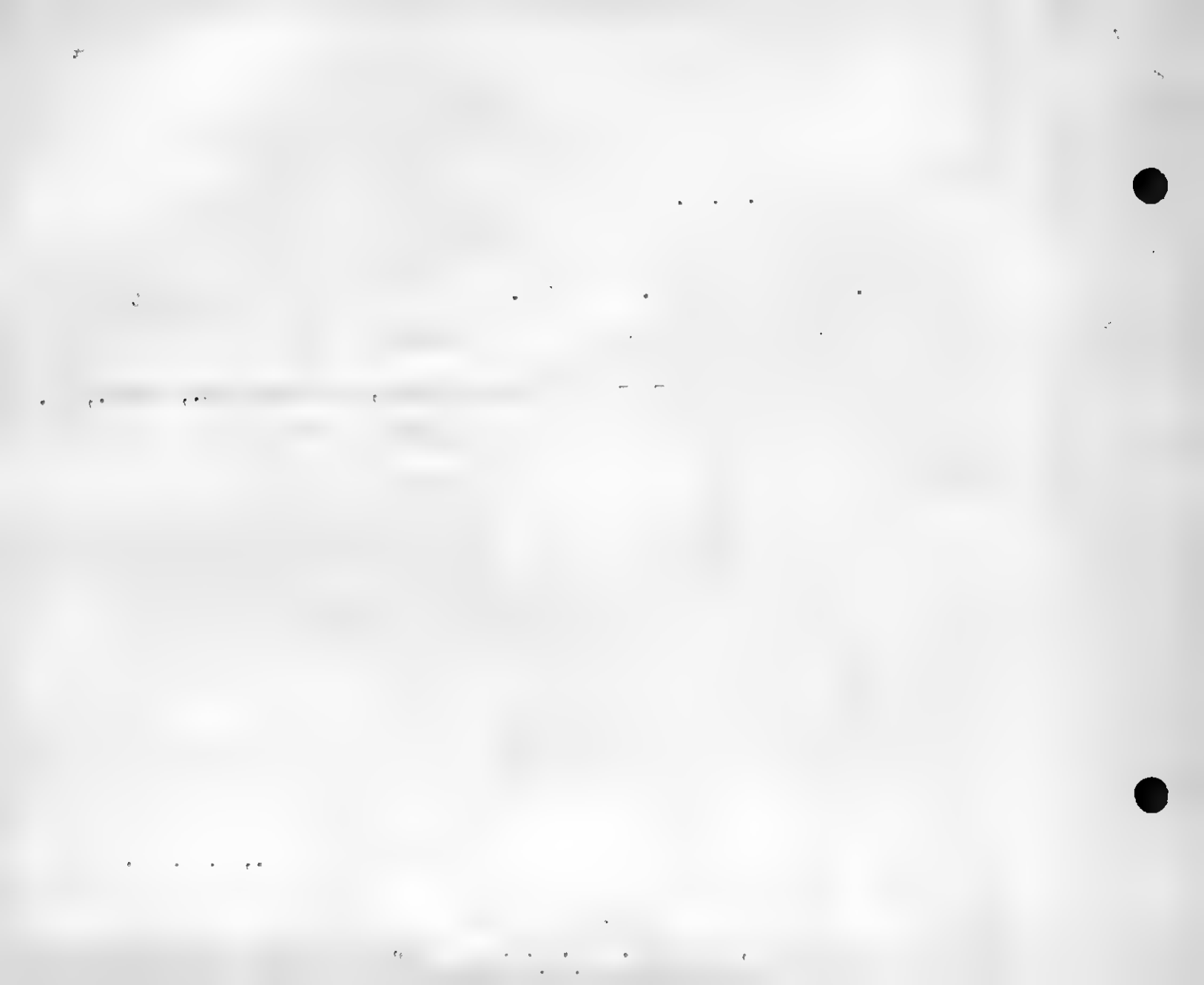
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17773

17784

1. DECEASED NAME (Type or print) <b>CARLIE</b> First Middle Last			2a. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>68</b>			2b. HOUR <b>4 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-20-2</b>		6. AGE (In years last birthday) <b>66</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Pa.</b>		13b. COUNTY <b>Phila.</b>		13c. CITY OR TOWN <b>Phila.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Amos</b> Middle Last		15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (if yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>199-01-1865B</b>		17. INFORMANT <b>Gregory Gonder, 1522 Brown St., Phila. Pa.</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral pneumonia, tubercles &amp; renal infection</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Paralysis of pharyngeal muscles</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral thrombosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b> <b>6 mo.</b> <b>6 mo.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>25XX</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (I either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 13, 1968</b> , to <b>Dec 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sydney Leventhal</b>		-DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/13/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Sydney Leventhal</b>		22e. ADDRESS <b>9210 Colesville Rd., S. S. Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wooster Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wooster, Ohio</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, 5130 Wis. Ave. N.W. Washington D. C. 20016</b>				25a. REC'D BY REGISTRAR <b>DEC 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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304M REV

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17785									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Peter			J.	Gounaris	Month 12 Day 24 Year 1968			10 a M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		White		17 June 1891		77 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
GREECE		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. WHAT OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville						RESTAURANT			
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER		
MARYLAND			MONTGOMERY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1424 BRIERWOOD TERR.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN -			GOUNARIS			PACHNE - UNK -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
NO			092-01-9640		HELEN - GOUNARIS				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								One Hour	
IMMEDIATE CAUSE (a) Respiratory Arrest									
DUE TO, OR AS A CONSEQUENCE OF									
Coronary Artery Disease									
(b) Bronchopneumonic Lung Disease, Chronic									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Parkinson's Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year						
22. INJURY OCCURRED			21a. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 5-15-1968, to 12-24-1968, that (I) (we) last saw the deceased alive on 12-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
George T Economos						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		12-24-68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
George T Economos						2141 K. St. N.W. Wash D. C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		26 Dec 1968		PARKLAWN CEMETERY		ROCKVILLE MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
KINDADI FUNERAL HOME, INC.		7400 GEORGIA AVE, NW		DATE DEC 27 1968		J. Charles Judge			





## CERTIFICATE OF DEATH

17786

1. DECEASED-NAME (Type or print) <b>Joseph Anthony R. Grand</b>		2a. DATE OF DEATH Dec Month 7 Day 1968 Year		2b. HOUR 1:15 M	
3 SEX <b>male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>6-8-1940</b>		6 AGE (In years last birthday) <b>28</b> YRS	7 UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md.
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Teacher</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Sil. Spr.</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>310 Brewster Ct.</b>
14 FATHER'S NAME First Middle Last <b>Joseph A. Grand</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Eileen -- Brewman</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO <b>Yes</b>		17 INFORMANT <b>Robert Grand</b>		Address <b>310 Brewster Ct.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> <b>429X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Months</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>429X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1968</b> , to <b>Dec 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert P. Montgomery, MD</b>		22c. DATE SIGNED <b>Dec 7, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>ROBERT P. MONTGOMERY</b>	
22e. ADDRESS <b>5411 CEDAR LANE BETHESDA, MD</b>		23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE <b>12-10-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Lee Warner E. Pumphrey, Inc.</b>		ADDRESS <b>Sil. Spr. Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH		2b. HOUR		
Willard Woodrow Grant						Month Day Year		10:20		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR		
M	W	Nov-09-21	47 YRS			Month Day Year		68/10/21		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
WS - VA.		US				Mont. Co				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park, Md.		Washington San & Hosp.		Dr. CHIROPRACTIC						
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		12109 New Hampshire Ave.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Julian Garnet Grant			Virginia Washington ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes			225 12 5073		MRS. MARY ALICE GRANT (SAME)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiorespiratory failure,										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) cause undetermined										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Dec. 6, 1968				
BELDEN R. YEAPHD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
			ADDRESS (Street, City, Town, or County)							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Dec. 10, 1968		Date of Heaven Cemetery		Montgomery Co. Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Takoma Funeral Home, J. Arthur Waller			254 Carroll St NW			DATE DEC 9 1968		J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <i>CLAIRE</i>		Middle <i>M</i>		Last <i>GRAY</i>		2a. DATE OF DEATH Month Day Year <i>DECEMBER 15 1968</i>		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>April 20, 1896</i>			6 AGE (In years last birthday) <i>72</i> YRS		2b. HOUR <i>6:30 A</i>		
7a. BIRTHPLACE (State or foreign country) <i>France</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.	
10. CITY OR TOWN OF DEATH <i>Keensington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carace Manor</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Teacher</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>VP G</i>		13c. CITY OR TOWN <i>Keensington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10300 Livingston Rd.</i>		
14. FATHER'S NAME First Middle Last <i>Emile Sullivan</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Claire Pajon</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT <i>Suzanne Roux</i>			Address <i>10300 Livingston Rd Keensington Md</i>			18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHRONIC MYOCARDITIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>GENERALIZED ARTERIOSCLEROSIS</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>SENILITY</i>											
19a. DATE OF OPERATION <i>7-22</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept - 30, 1968</i> , to <i>Dec 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Henry J. Forden MD</i>			22c. DATE SIGNED <i>12/15/68</i>			22d. PHYSICIAN'S NAME (Type) <i>Henry J. Forden MD</i>			22e. ADDRESS <i>5306 Morning Dr. Chevy Chase, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>			23b. DATE <i>12-17-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Marys Church Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Pescataway Md.</i>		
24. FUNERAL DIRECTOR <i>Robert E. Winkler</i>			4308 <i>Switzerland Md</i>			25a. REC'D BY REGISTRAR <i>DEC 24 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First EDITH			Middle M			Last GRAY			2a. DATE OF DEATH Month Day Year DECEMBER 24 1968			2b. HOUR 5 <sup>15</sup> P M		
3. SEX 7			4. RACE W			5. DATE OF BIRTH Oct. 2 - 1895			6. AGE (In years lost birthday) 73 YRS.			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN			8. UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) Mich.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md								
10. CITY OR TOWN OF DEATH KENSINGTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL HALL SAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) DRY CLEANING			12b. KIND OF BUSINESS OR INDUSTRY Jewelry								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince Georges			13c. CITY OR TOWN Capitol Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5810 Walker Mill Rd					
14. FATHER'S NAME John			First Middle Last H BAYNE			15. MOTHER'S MAIDEN NAME MARY ELLEN DACEY			First Middle Last DACEY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 579-28-2346			17. INFORMANT Dustine J. Lashinski			Address Same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS												72 HOURS					
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
(b) ARTERIOSCLEROTIC HEART DISEASE																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) GENERALIZED ARTERIOSCLEROSIS																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
7 years SENILITY																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 10-30, 1968, to 12-24, 1968, that (I) (we) last saw the deceased alive on DEC. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Henry J. Snowden			DEGREE MD			ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/24/68								
22d. PHYSICIAN'S NAME (Type) HENRY J. SNOWDEN			22e. ADDRESS 529 E. Parkway Dr. Cherry Chase, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12-28-1968			23c. NAME OF CEMETERY OR CREMATORY EPIPHANY CEMETERY			23d. LOCATION (City or town) (County) (State) FORESTVILLE MD								
24. FUNERAL DIRECTOR W.W. Chambers Co			ADDRESS 517-11th St SE			25a. REC'D BY REGISTRAR DEC 31 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

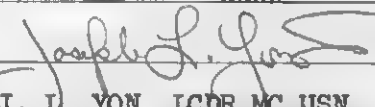





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>DONNA J. GREEN</b>						2a. DATE OF DEATH Month Day Year <b>DEC 22 1968</b>			2b. HOUR <b>3:00A</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>1 MAY 1929</b>			6. AGE (In years last birthday) <b>40 39</b> RS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>WYOMING</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOME Y</b>			Md		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>INDIAN HEAD</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>RT 1, BOX 61</b>		
14. FATHER'S NAME First Middle Last <b>RUDOLPH D. ZABLODITZ</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>ALICE SUCHANEK</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-38-5920</b>		17. INFORMANT <b>JOSEPH C. GREEN</b>			Address <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <b>Septicemia</b>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <b>Carcinoma of the Cervix</b>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
<b>171X</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>26 NOV</b> , 19 <b>68</b> , to <b>22 DEC</b> , 19 <b>68</b> , that <del>we</del> (we) last saw the deceased alive on <b>22 DEC</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) (did) <del>not</del> view the body after death.												
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>22 December 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>J. L. YON, LCDR MC USN</b>						22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>						
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-26-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>					
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.</b>						25a. REC'D BY REG. STRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE 				
<b>LaPlata, Maryland</b>												



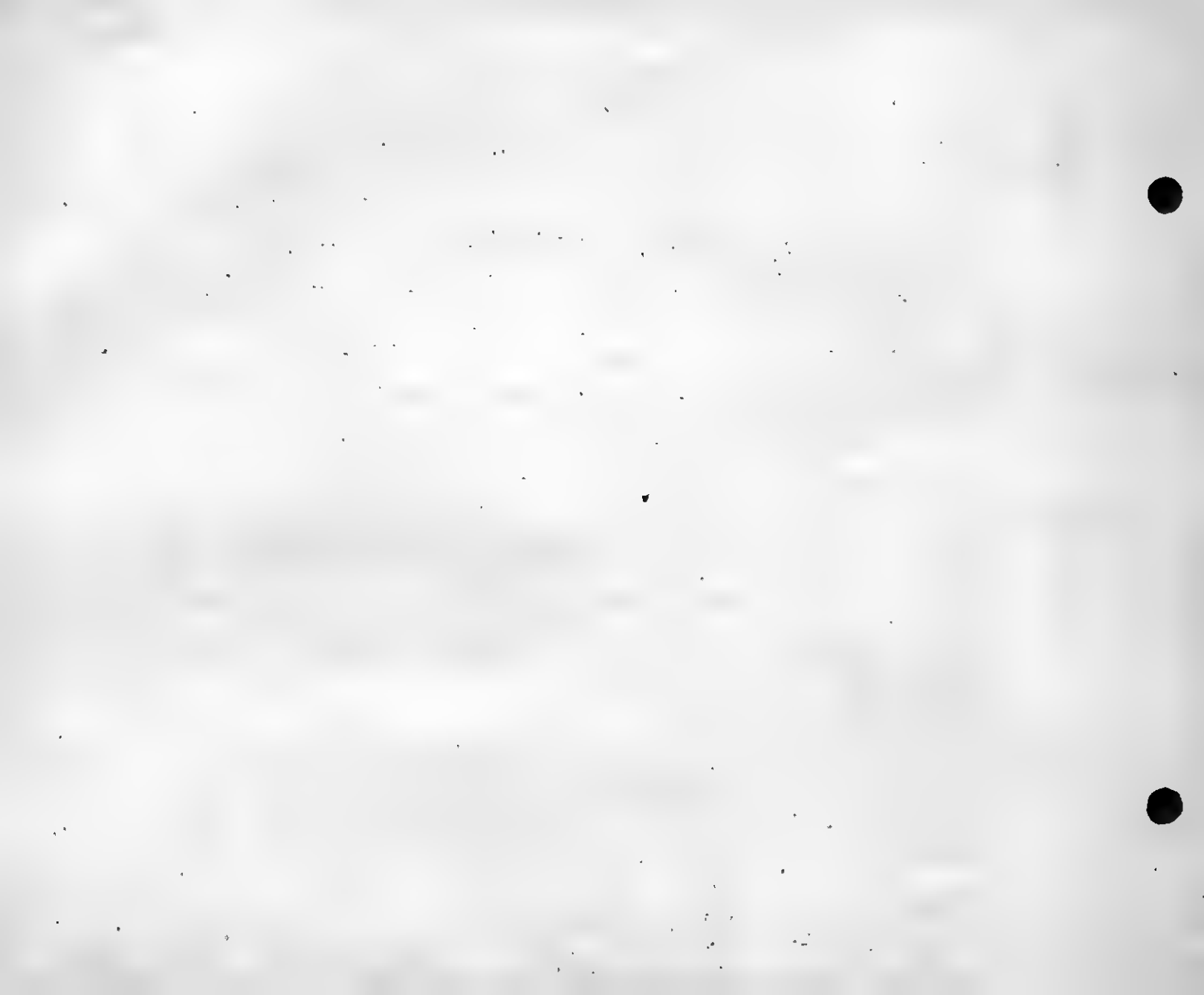
## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ARTHUR Griffith</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>68</b>			2b. HOUR <b>3:45 PM</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH <b>11-3-93</b>		6. AGE (in years lost birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1000 Oakwood Ave Silver Spring, Md.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Gen. Elec.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>405 Greenbriar Dr.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>T</b> Last <b>Griffin</b>			15. MOTHER'S MAIDEN NAME First <b>Gertrude</b> Middle <b>Brown</b> Last <b>Brown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO <b>216-44-2772</b>			17. INFORMANT <b>Loth Robinson RN</b>			Address <b>2325-15th St. N.W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Metastatic anaplastic carcinoma</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>+</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>+</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>11.</b>											
19a. DATE OF OPERATION <b>1968</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>As above</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR <b>AM</b> Month <b>Day</b> Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , 19 <b>Dec 7</b> , 1968, that (I) (we) last saw the deceased alive on <b>Dec 6</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Bennet A. Porter, Jr. M.D.</b> DEGREE <b>ATTENDING</b> <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS.						22c. DATE SIGNED <b>December 7, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr. M.D.</b>						22e. ADDRESS <b>9301 Colesville Rd, Silver Spring, Md.</b>					
23a. BURIAL (CREMATION, REMOVAL) (Specify)			23b. DATE <b>12-10-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>			23d. LOCATION (City or Town) (County) (State) <b>COLEMAN MANOR MD</b>		
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b> ADDRESS <b>WASH. D.C.</b> <b>W.W. CHAMBERS Co. 1400 CHAPIN ST. N.W.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4 1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17781										17792									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
Item 23 Film 408 1/7/69 kk										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH				2b. HOUR						
John			Kimberly		Griggs		Month December Day 23 Year 1968				4:23 PM								
3. SEX			4 RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.						
Male			White		26 November 1957				11 YRS.		MONTHS DAYS		HOURS MIN.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH										
Georgia			USA		WIDOWED		DIVORCED		Montgomery				Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda			The Clinical Center, NIH				student				None								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER										
Maryland			Montgomery		Takoma Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		704 Gilbert Street										
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last						
James C.			Griggs		Laura		Chalker												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT				The Medical Record Address										
No			None		The Clinical Center, NIH, Bethesda, Maryland														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic shock										15 minutes									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Systemic candidiasis		2 weeks							
										(c) Acute lymphocytic leukemia		2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes					
21a. ACCIDENT WAS UNDERLYING										21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>																			
22a. I certify that (H) (this hospital) attended the deceased from Nov. 30, 1968, to Dec. 23, 1968, that (H) (we) last saw the deceased alive on December 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED					
David H. Riddick, M.D.														December 23, 1968					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS									
										The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, or other disposition			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)										
Burial - Transit			12/24/68		Forest Hill				Eastpoint, Ga.										
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Tyson Wheeler F.H. 1331 Rockville Pk. Rockville, Md.										DATE DEC 27 1968		Charles Judge							



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
45M - 1968

17793		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17793	
Mamie Ager Grosch					
1. DECEASED-NAME (Type or print) <b>MAMIE</b> First <b>AGER</b> Middle <b>Grosch</b> Last			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>1968</b>		2b. HOUR <b>5:45</b> M
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>10/18/189</b>		6 AGE (In years last birthday) <b>79</b> YRS	7. UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>
7a BIRTHPLACE (State or foreign country) <b>Pdla Pa</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED VET. ADMIN.</b>	12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a USUA. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>Md</b>	13b CITY OR TOWN <b>Montgomery</b>	13c CITY OR TOWN <b>Silver Spring</b>	13d ASIDE CITY LIM TSP? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>3900 BEL PRE ROAD.</b>	
14. FATHER'S NAME First <b>Walter F</b> Middle <b>Anthony</b> Last	15 MOTHER'S MAIDEN NAME First <b>Katherine L.</b> Middle <b>McMahon</b> Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service) <b>WW-I</b>	16b SOCIAL SECURITY NO. <b>579-31-5355A</b>	17 INFORMANT <b>Katherine McMahon, daughter</b> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b> <b>4/1/73</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>arteriosclerosis of iliacs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure &amp; Arteriosclerotic Heart Disease</b> <b>many years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>200 min</b> <b>200 days</b> <b>many years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>45</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (i) (this hospital) attended the deceased from <b>May</b> , 19 <b>63</b> , to <b>Dec 22</b> , 19 <b>68</b> , that (i) (we) <del>was</del> saw the deceased alive on <b>Dec 21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) <del>did</del> (did not) view the body after death.					
22b SIGNATURE <b>George H. Mitchell M.D.</b> DEGREE <b>MED</b> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <b>12/22/68</b>	
22d PHYSICIAN'S NAME (Type) <b>George H. Mitchell</b>				22e. ADDRESS <b>11125 Rockville Pike, Rockville, Md.</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>12-26-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Montgomery Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5150 Wisconsin Ave. N.W., Wash., D.C., 20016</b>			24a REC'D BY REGISTRAR <b>DEC 27 1968</b>	25b REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	





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CLERK WITH MEDICAL EXAMINEE 12-26-68

17783

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17794

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Paul M. Grubb			2a. DATE OF DEATH Month Day Year 12 21 68			2b. HOUR 10:20 AM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 5/14/05		6. AGE (In years lost birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Silver Spg.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Wheaton Plaza Theatre		12b. KIND OF BUSINESS OR INDUSTRY Manager					
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8708 First Ave.			
14. FATHER'S NAME First Middle Last James Frank Grubb			15. MOTHER'S MAIDEN NAME First Middle Last Lulu -- Nunn								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) (If yes, give war or dates of service) yes WW II		16b. SOCIAL SECURITY NO. 413-09-6150		17. INFORMANT Mrs. <del>Lenore</del> Lenore Grubb		Address Sil. Spg., Md. 8708 First Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CEREAL DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 2-3 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32 DAYS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITUS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 11-19, 1968, to 12-24, 1968, that (I) (we) last saw the deceased alive on 12-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harold S. S. S.		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/24/68					
22d. PHYSICIAN'S NAME (Type) Harold S. S. S.		22e. ADDRESS 13584 NW Blvd									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-26-1968		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION (City or Town) Freeport		County Stephenson, Ill.		State	
24. FUNERAL DIRECTOR C. Glen Carter		ADDRESS Sil. Spg. Md.		25a. REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					
Funeral E. Pumphrey, Inc. 8434 Georgia Avenue											



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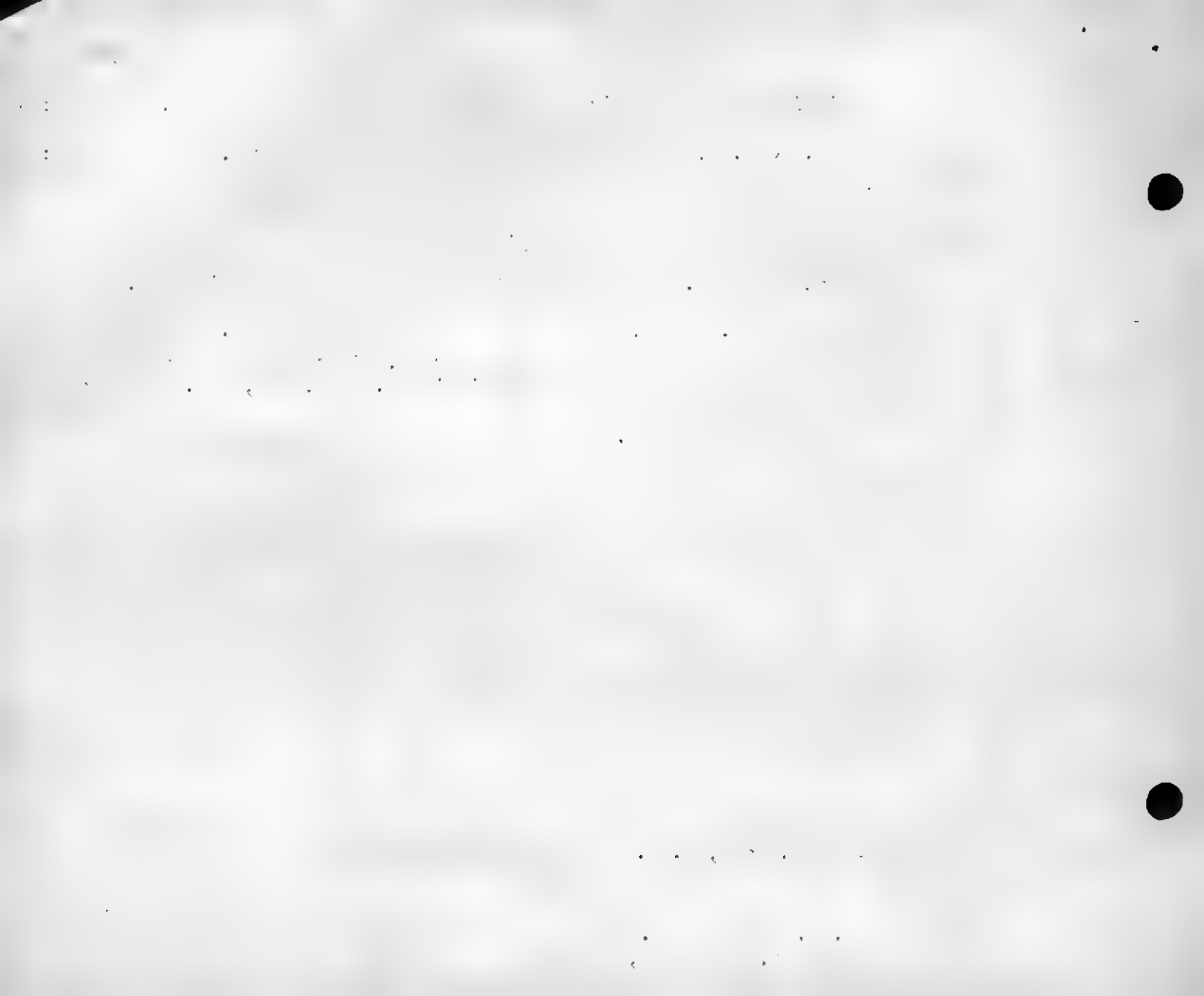
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
EDWARD MORRIS HAAS					12 Month 16 Day 68 Year		5 P M	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE	CAUCASIAN	6/3/80			88 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CIT. ZEN OF WHAT COUNTRY?	8. MARRIED		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Pennsylvania	USA	WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY		Printing		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK	WASHINGTON SAN. & HOSP.		ENGRAVER		Printing			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND	MONTGOMERY	SILVER SPRING			8811 Cdesville Rd.			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last		
?	(Unknown)		?	?		(Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address
No		--		220-44-7885		Helen Anderson		Sil. Spr. Md. 13606 Layhill Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>								5 hour
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - generalized</u>								5 years
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 1967</u> , to <u>Dec 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
Harry N. Carlton, MD		Dec 10, 1968		HARRY N. CARLTON				
22e. ADDRESS		22f. ADDRESS						
8811 Cdesville Rd, Silver Spring, Md.								
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Buried		12-13-1968		St. Lincoln Cemetery		Prince Georges, Maryland		
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc.		8434 Georgia Avenue		DEC 16 1968		Charles Judge		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
William Frederick HAHN						Month Day Year			4:05 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	Cauc.	Oct. 2, 1946	22 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	4:05 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Missouri		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			Student			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER		
Maryland			Pr. George		College Park	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7403 Hawkins Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last William R. HAHN			First Middle Last Marian G. Kammerer						
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			265 90 3709		Drive, Winter Park Florida CDR William R. Hahn, USN, Ret. 2112 Fosgate				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Periodic paralysis, sporadic</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>type, Clinical</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypokalemia</u>									4 hr.
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
<u>John G. Ball</u>			M.D.			31 December 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
John G. Ball, M. D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		JAN 6, 1969		DeLand Memorial Garden		DeLand		VOLUSIA COUNTY	FLORIDA
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. W. Chambers Co.					ADDRESS		DATE		
5801 Cleveland Ave. Riverdale, Maryland							JAN 14 1969		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

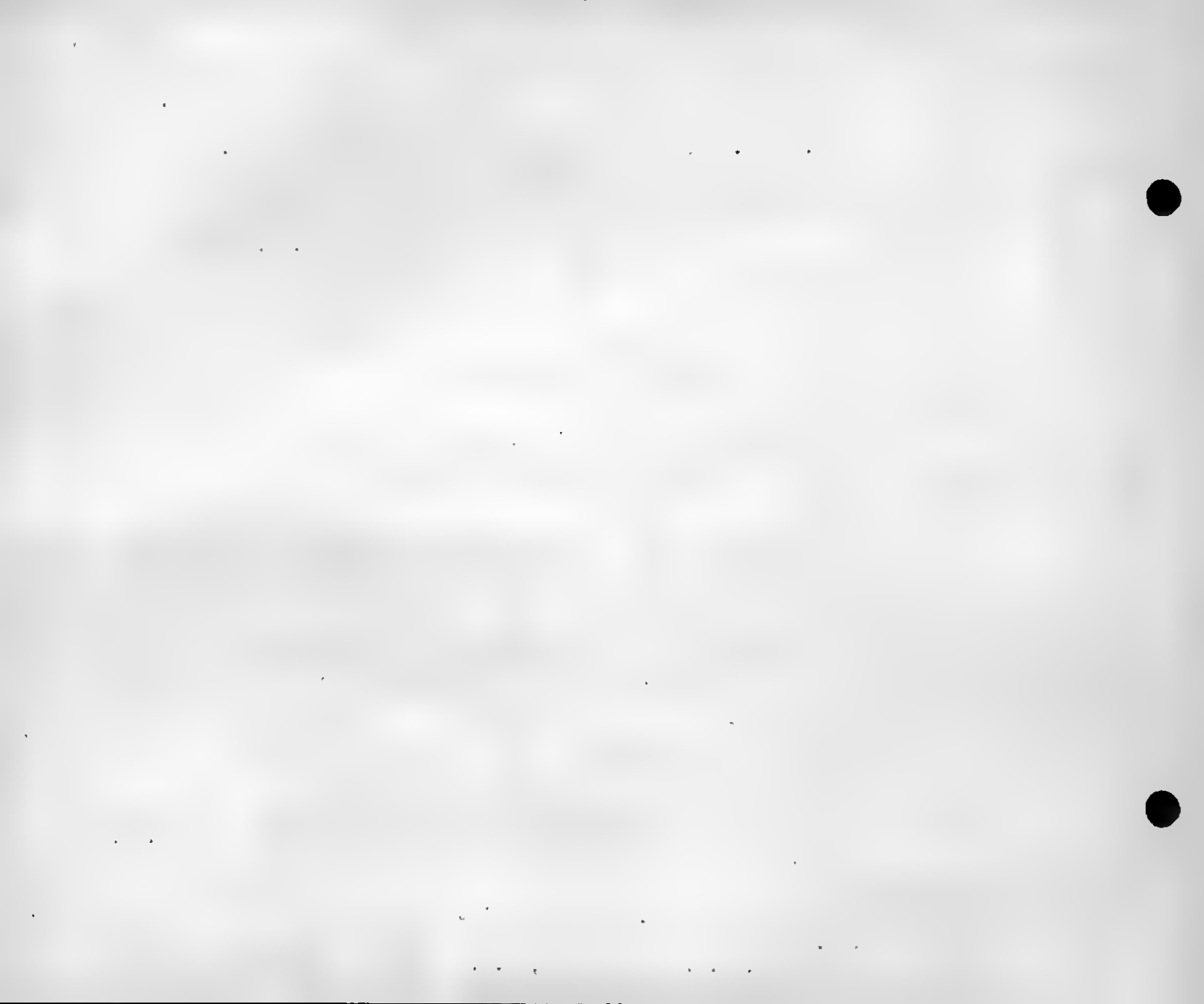
17786

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17797

1 DECEASED-NAME (Type or Print)		First Burnell		Middle Hughes		Last HAINES		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> DEC. 1 1968		2b HOUR 340A			
3 SEX MALE		4 RACE CAUCA.		5. DATE OF BIRTH FEB. 15, 1940		6 AGE (in years at birthday) 28 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md							
10 CITY OR TOWN OF DEATH Bethesda				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) U. S. Navy				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Job		13c CITY OR TOWN New Windsor		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Route 1			
14. FATHER'S NAME First Middle Last Ralph Anthony Haines				15 MOTHER'S MAIDEN NAME First Middle Last Bessie Katherine Hughes									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b SOCIAL SECURITY NO. (If not yet was holder of service) 1958-68		17. INFORMANT Navy Records		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Multiple injuries, severe DUE TO, OR AS A CONSEQUENCE OF (b) Trauma from auto accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 336 PM DEC. 1 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) loss control of car and hit a wall							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f LOCATION Street or RFD No RT124,		City or Town Gaithersburg		County Montgomery		State MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED DEC. 3, 1968					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-5-68		23c NAME OF CEMETERY OR CREMATORY St. James Methodist Cemetery				23d. LOCATION (City or Town) Dennings		(County) (State) Md.			
24 FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin Street, N.W., Washington, D.C.				25a REC'D BY REGISTRAR DEC 9 1968				25b REGISTRAR'S SIGNATURE Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
George					Haines	Dec. 27, 1968		1:20 P.M.	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Cauc.		June 28, 1895		73 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U. S.				Montgomery		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Potomac Valley Nursing Home		Painter (Retired)					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP		13e. STREET AND NUMBER	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		208 Harrison Street	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S M.A.DEN NAME			First Middle Last
George					Haines	Mary			(Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address
No			214-12-7068			Lola G. Haines			208 Harrison St. Rockville, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Metastatic carcinoma (adeno)</u> 1-19-1									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary artery disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>12-27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald L. Bucy</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) DONALD L. BUCY					22e. ADDRESS 809 Veirs Mill Rd. Rockville, Maryland				
23a. BURIAL-CREMATATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Dec. 30, 1968				Forest Oak Cemetery		Gaithersburg, Montgomery Md			
24. FUNERAL DIRECTOR					ADDRESS		25a. REGISTERED DEATH REGISTRAR'S SIGNATURE		
Robert A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md.							JAN 10 1969		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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*Send with Mrs. G. Warner*

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <i>Mrs. Olive -- Halbruner</i>			2a. DATE OF DEATH Month Day Year <i>12 19 68</i>			2b. HOUR <i>3:00 AM</i>				
3. SEX <i>F</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>5-13-86</i>		6 AGE (In years last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>own home</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Sil. Spr.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2605 Glenallen Avenue</i>		
14. FATHER'S NAME First Middle Last <i>Joseph -- Jozur</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>(unknown)</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>yes</i>		17 INFORMANT <i>Franklin Halbruner</i>		Address <i>Sil. Spr., Md.</i> <i>2605 Glenallen Avenue</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cerebrovascular accident</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary atherosclerosis</i> 96b									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>11/19</i> , 19 <i>68</i> , to <i>12/19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/19</i> , 19 <i>68</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Lewis H. Deane</i> MD		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/19/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Lewis H. Deane</i>		22e. ADDRESS <i>2506 Red Pre Rd, Silver Spring, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-23-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cold Spring Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Cold Spring, New Jersey</i>				
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>Silver Spr. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A  
45M

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <b>LOLA</b>			Middle <b>MAY</b>			Last <b>HALL</b>			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>11:30</b>		
3 SEX <b>Female</b>			4 RACE <b>White</b>			5 DATE OF BIRTH <b>July 28, 1880</b>			6 AGE (In years last birthday) <b>88</b> YRS			7 UNDER YEAR MONTHS <b>11</b> YEARS DAYS <b>30</b>			8 UNDER 24 HRS HOURS <b>11</b> MIN <b>30</b>		
7a BIRTHPLACE (State or foreign country) <b>Kansas</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>								
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Althea Woodland Nurs-</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Public Sch-</b>								
3a USUA. RESIDENCE (Where deceased lived, if institution, give name of institution) STATE <b>Maryland</b>			13b COUNTY <b>Montgomery</b>			13c CITY OR TOWN <b>Bethesda</b>			3d INSIDE CITY, J.M. 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>6110 Bradley Blvd.</b>					
14. FATHER'S NAME First <b>Nathan</b> Middle <b>Davis</b> Last <b>Abigail</b>			15 MOTHER'S MAIDEN NAME First <b>Abigail</b> Middle <b>Newby</b> Last <b>6110</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service) <b>***</b>			16b. SOCIAL SECURITY NO. <b>216-46-0491</b>			17 INFORMANT <b>Mr. Robert McCormick, Bethesda, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severals</b> Approximate interval between onset and death <b>1 month</b>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) <del>(we)</del> attended the deceased from <b>1964</b> , 19 <b>Dec 24</b> , 19 <b>68</b> , that (I) <del>(we)</del> saw the deceased alive on <b>Nov 29</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.																	
22b. SIGNATURE <b>James W Egan M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>Dec 25-1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>JAMES W. EGAN, M.D.</b>			22e. ADDRESS <b>5413 Cedar Lane - Bethesda, Md</b>														
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>			23b. DATE <b>12/26/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Pr. Geo. Md.</b>								
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY,</b>			7557 Wisconsin Ave. <b>Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form 7-10-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17790

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17801

1 DECEASED NAME (Type or Print) <i>Charles H Hallman</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12 2 1968			2b HOUR 1:30 PM		
3 SEX <i>Male</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>July 12 1921</i>	6 AGE (In years last birthday) <i>47</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <i>Dec.</i> Day <i>2</i> Year <i>1968</i>		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Dickinson</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Route 2</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Truck Collector</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Dickinson</i>		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>Rt # 2</i>
14. FATHER'S NAME First Middle Last <i>John H Hallman</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Florence Only</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Thrombosis Acute.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Coronary Arterio Sclerosis -</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> <i>years.</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4x01</i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John B. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>Dec 2, 1968</i>		
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>12-5-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mt Zion Ch. Cemetery Sellman</i>		23d LOCATION (City or town) (County) (State) <i>Montg. Md.</i>		
24 FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville Md</i>		25a REC'D BY REG STRAR DATE <i>DEC 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Jones</i>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE ON

1 DECEASED NAME (Type or print)				First		Middle		Last		2a DATE OF DEATH				2b HOUR	
Kermit Elwood				Hamilton						12 13 68				1:58 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		white		8-9-33				35 YRS		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH							
Virginia		United States		WIDOWED		DIVORCED		Montgomery Co		Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Sanitarium				Electrician - unemployed									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
Maryland Prince George's		Delphi		YES		NO		9302 Delphi Rd		Cpt 103					
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
								Blanche		Hamilton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or at unknown)		16b SOCIAL SECURITY NO		17 INFORMANT				Address							
No		230 36 0184		Washington Sanitarium Records				Takoma Park Md							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Coma										2 wks					
571.0 DUE TO, OR AS A CONSEQUENCE OF															
Laennec's Cirrhosis										several years					
DUE TO, OR AS A CONSEQUENCE OF															
Peptic Ulcer															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES NO									
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year													
		P.M. 19													
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No.		City or Town		County		State			
While <input type="checkbox"/> Not while <input type="checkbox"/>															
at work <input type="checkbox"/> at work <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from 11/29, 1968, to 12/13, 1968, that (I) (we) last saw the deceased alive on 12/13, 1968, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)				22e ADDRESS							
Israel Spector MD		12/13/68		ISRAEL SPECTOR		Silver Springs, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)					
burial		Dec 16, 1968		Ft Lincoln Cemetery		Colmar Manor		Pro Geo		Md.					
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
F. Gasch's Sons		Hyattsville, Md.		DEC 18 1968		Charles Judge									



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

177012

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17803

1. DECEASED NAME (Type or Print) <b>Mabel C. Hanley</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Dec. 5 1968			2b. HOUR <b>4:25</b> M		
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>7/6/1911</b>	6. AGE (in years last birthday) <b>57</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>Dec</b> Day <b>5</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5402 Christy Drive</b>
14. FATHER'S NAME First <b>Harry</b> Middle <b>Coggins</b> Last <b>Coggins</b>			15. MOTHER'S MAIDEN NAME First <b>Ernestine</b> Middle <b>Hammack</b> Last <b>Drive</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Calanthe H. Spencer</b>			ADDRESS <b>-90220 Oceanwood Drive</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diabetic Coma with Acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1500</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours?</b> <b>years.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>x Emaciation - Metabolic Deficiency</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John B. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <b>Dec - 5, 1968</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>The S.H. Hines Co. Washington, D. C.</b>				25a. REC'D BY REGISTRAR <b>DEC 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17203 CERTIFICATE OF DEATH 17804									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Louise Theresa Harmuth						12 Month 18 Day 68 Year			10:30 AM
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Female		Caus.		8/13/1894		74 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Brooklyn, N.Y.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		University Nursing Home		Machine operator					
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				808 Horton Drive	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
George Aplustille						Theresa Schmidt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address
No			121-20-1448 B			WILLIAM HARMUTH			SAME AS #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Coronary vascular accident</u>									one day
DUE TO, OR AS A CONSEQUENCE OF <u>Multiple myeloma</u>									one year
CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
203 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 18, 1967</u> to <u>Dec 18, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE					EDWARD ADOLPH H.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
Edward Adolph H.D.									Dec. 18, 1968
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					1100 22nd ST N.W. Wash D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Dec. 20, 1968		Geo. Washington		Prince George		Md.	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Adolph					DEC 27 1968		Charles Judge		



# FOR STATE HEALTH DEPT.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17805

1. DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Robert Cline Harris						Month Day Year			9:15 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	May 22, 1923	45 YRS	MONTHS	DAYS	HOURS	M.N.	Month Day Year			9:25 AM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Virginia		USA		WIDOWED		DIVORCED		Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban			Sales Clerk			Super Giant		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Anne Arundel			Annapolis Jct.			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S M A D E N NAME			13e STREET AND NUMBER					
First Middle Last			First Middle Last			PO Box 47					
William Jennings Harris			Hazel A. Calley								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
Yes			Army			579-14 4684 Ruth Harris / 579-14 4684			579-14 4684		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute -</u>									Sudden		
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease.</u>									years.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.			19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John B. Ball			CHIEF MEDICAL EXAMINER			22b DATE SIGNED -		
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MEDICAL EXAMINER			DEC 16, 1968		
						DEPUTY MEDICAL EXAMINER					
						ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			12-19-68			Union Cemetery			Baltimore Md.		
24 FUNERAL DIRECTOR			ADDRESS			25 REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Canadian Funeral Home Laundry						DEC 23 1968					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17806									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
John			Vernon Harrison			December 17		11:15	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		August 30th 1968		YRS. MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Wash., D.C.		U.S.A.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Spring			Holy Cross			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Montgomery			Bladensburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			5200			
James Vernon Harrison			Glenda			V		Woodruff	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
						Hospital Records			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Cardiac Arrest									
3479 DUE TO, OR AS A CONSEQUENCE OF									
Aspiration									
DUE TO, OR AS A CONSEQUENCE OF									
Status post Craniotomy									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
Internal Hydrocephalus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
12-18-68		Hydrocephalus		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from 12-17, 1968 to 12-18, 1968, that (I) (we) last saw the deceased alive on 12-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Jonathan M. Williams MD		12-19-68		Jonathan M. Williams MD		808 Pershing Dr. Silver Spring			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		12-21-68		Forest Hill		Baltimore Prince Georges			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
B.H. Matthey		131-11th St		DEC 23 1968		M. J. Jones Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove/carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH										17807	
1. DECEASED NAME (Type or print) <b>OLLIE JENNINGS HARRISON</b>						2a. DATE OF DEATH 12 Month 13 Day 68 Year			2b. HOUR 9:30 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-10-00		6. AGE (In years last birthday) 68 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Beltzville		13c. CITY OR TOWN Beltzville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4421 Powder Mill Rd.		
14. FATHER'S NAME First Middle Last Walter Harrison				15. MOTHER'S MAIDEN NAME First Middle Last Lillie GRAVES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 578-48-2203		17. INFORMANT Patients CHART			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the Distal Esophagus</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophagus</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bacteremia</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>150x</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1. Deep Disease</u> (b) <u>Emphysema</u> (c) <u>Respiratory</u>											
19a. DATE OF OPERATION 11/22/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of the Distal Esophagus			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from November, 1968, to Dec. 13, 1968, that (I) (we) last saw the deceased alive on 12-13-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (did not) view the body after death											
22b. SIGNATURE Alan R. Gair						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/13/68		
22d. PHYSICIAN'S NAME (Type) ALAN R. GAIR M.D.						22e. ADDRESS 3118 Craighawn Rd, Beltsville, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE DEC 18 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge		



12/19/68  
 cleared by Dr. Reed in  
 (Medical Examiner)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
EMMA			HARVEY			DEC, Month 19 Day 1968 Year		1004 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
FEMALE		WHITE		2/25/1891		77 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
England		U.S.				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING.		WHEATON NURSING HOME		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Penna <del>XXXXX</del>		XXXXXX		Saratoga		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		XXXXXX XXXXXX XXXXXX XXXXXX	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Green			Emily Newbold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes, no, or (unknown)		193-40-8252		Silver Spring, Md. Address Mrs. George Morrison 1009 Strout Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS									24 HRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									1-2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERY ATHEROSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
RECENT LEFT HIP FRACTURE (10/19/68)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
10/24/68		FRACTURE LEFT HIP.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 10 19 1968		SPONTANEOUS FRACTURE					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		HOME		AS ABOVE					
22a. I certify that (1) (this hospital) attended the deceased from DEC 19 53, to DEC 19, 1968, that (1) (we) lost saw the deceased alive on DEC 18 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
James A. Roberts M.D.				12/19/68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
JAMES A. ROBERTS				8907 GEORGIA AVE SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec 21 1968		St. Lincoln Cemetery		Prince George County, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc. 8434 Ga. Ave.		C. Glen Carter Silver Spg, Md.		DEC 23 1968		J. Charles Younger			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17788									
17809									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
ALFRED			HARTMANN			HAUSRATH		12 3 08 7 45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		CAUS.		7/2/1871		97 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
NEW YORK		USA				MONT		WHEATON Md.	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INS OF CITY LIMITS?		13b. STREET AND NUMBER	
UNIVERSITY MRSINGTONA		MUSICIAN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		120 HULLTOP Rd S.S.	
13c. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13d. CITY OR TOWN		13e. INS OF CITY LIMITS?		13f. STREET AND NUMBER		14. FATHER'S NAME	
Md		MONT		SILVER SPRING				FREDERICK E HAUSRATH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		18. ADDRESS		19. MOTHER'S MAIDEN NAME	
		104-30-1894		ALFRED HAUSRATH (SON)		120 HULLTOP Rd S.S. MD.		ELIZABETH HARTMANN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Arteriosclerosis, generalized									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4500									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. PLACE OF INJURY		21e. LOCATION	
<input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH		HOUR AM Month Day Year		(Enter nature of injury in Part 1 or Part 2, Item 18.)		(AT HOME, FARM, STREET, FACTORY)		Street or R.F.D. No City or Town County State	
(If either, notify medical examiner)		P.M. 19				OFFICE BUILDING, ETC			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION		21h. LOCATION	
While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No		City or Town		County State	
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19 to December 6, 1968, that (I) (we) last saw the deceased alive on December 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d,d) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS	
Bennet A. Porter, M.D.		December 6, 1968		Bennet A. Porter, Jr., M.D.		9301 Coleville Rd, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. LOCATION (City or Town)	
Cremation		Dec 7, 1968		Arlington Cemetery		Silver Spring, Md		Silver Spring, Md	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. ADDRESS		24c. ADDRESS		24d. ADDRESS	
Walter's Mortuary		254 Carroll St. N.W.		254 Carroll St. N.W.		254 Carroll St. N.W.		254 Carroll St. N.W.	
25. RECD BY REGISTRAR		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
DEC 9 1968		Charles Judge		Charles Judge		Charles Judge		Charles Judge	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17810				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or Print)			First MYRTLE		Middle (none)		Last HAVENER		2a DATE KNOWN OF DEATH		2b HOUR			
3 SEX Female			4 RACE White		5 DATE OF BIRTH Dec 2, 1968		6 AGE (in years last birthday) 83 YRS		7c MONTHS Unknown		7d MIN.			
7a BIRTHPLACE (State or foreign country) Maryland			7b CIT. ZEN OF WHAT COUNTRY? Montgomery			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c DATE PRONOUNCED DEAD Month Day Year Dec - 22 1968		2d HOUR 5:30 P.M.			
10 CITY OR TOWN OF DEATH Potomac			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Falls Road			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) at Home			12b KIND OF BUSINESS OR INDUSTRY at Home			Md.		
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Potomac			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER Falla Road Potomac, Md		
14. FATHER'S NAME First Middle Last Mason A. Haverer			15. MOTHER'S MAIDEN NAME First Middle Last Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give year or dates of service) None			17. INFORMANT Nora Lee Broches			ADDRESS 4264 S. 16th St Arlington, Va					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 4119 IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John G. Ball						M.D.			22b DATE SIGNED Dec - 2, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-5-68		23c. NAME OF CEMETERY OR CREMATORY Walkers Chapel Cemetery			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia						
24. FUNERAL DIRECTOR Robert A. Pumphrey			7557 Wisconsin Ave Bethesda, Md			25a. REC'D BY REG. STRAR DATE DEC 9 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge					

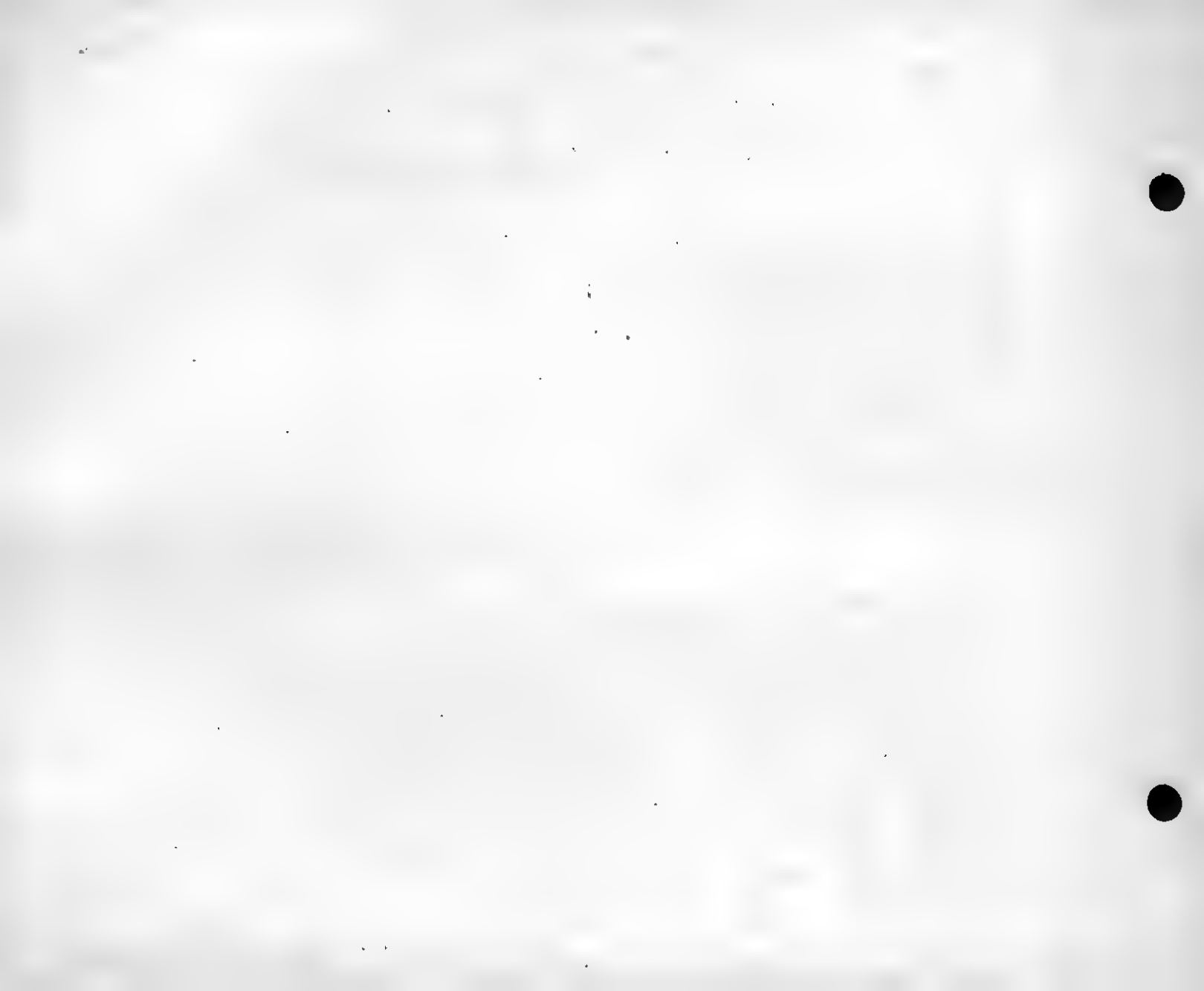


**FOR STATE  
HEALTH DEPT.**

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Herbert King Hawkins						EST. <input type="checkbox"/> Month Day Year			7 M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
M.	Negro.	6-29-1932	36 YRS					Dec Day 25 Year 1968	3 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			MD
MARYLAND		U.S.A.				Montgomery			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville		915 Stone Street Ave.				Waiter		None	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Montgomery		Rockville				
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A DEN NAME First Middle Last						
PARRER HAWKINS			CUGLER KING						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
					MRS ERMA L. SULLIVAN		WASHINGTON D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration and Maceration of Brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gun Shot Wound of Hand</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>781X</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 7 P.M. Dec 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Shot in Hand 22 cal gun</u>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Car parked in street</u>		21f LOCATION Street or R.F.D. No <u>915 Stone Street Ave.</u>		City or Town <u>Rockville</u>		County <u>Montgomery</u>	State <u>MD</u>
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <u>Dec. 25, 1968</u>	
John B. Bell									
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL			12-30-68		Brooke Grove Cem		Laytonsville Montg Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE	
Robert L. Snowden			Rockville Md.			AN 3 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

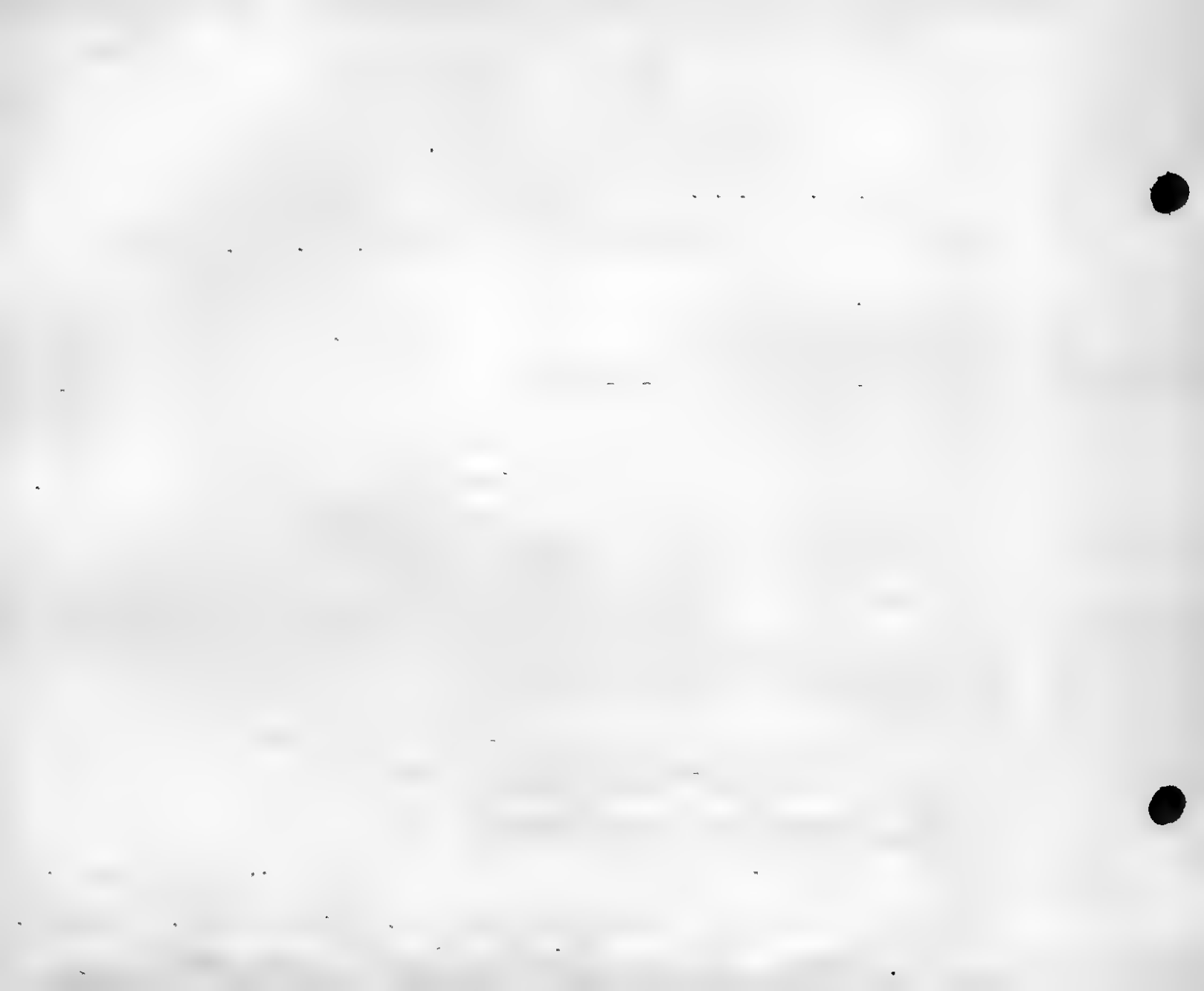
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17891

CERTIFICATE OF DEATH

17312

1. DECEASED-NAME (Type or print) <i>Frances. Pauline Haxton</i>			2a. DATE OF DEATH <i>Month 2 Day Year</i>		2b. HOUR <i>5:35 PM</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>May 25, 1894</i>		6 AGE (In years last birthday) <i>74 YRS.</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Washington, Va.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery Md</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Cedar Haven Rest Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Gov't.</i>	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Boys</i>	13c. CITY OR TOWN <i>Boys</i>	13d. INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Route #1 Box 65</i>
14. FATHER'S NAME First <i>Thomas Wayland</i> Middle <i>MONIC</i> Last			15 MOTHER'S MAIDEN NAME First <i>Mary E. Grimsley</i> Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>215-46-2082</i>	17 INFORMANT Address <i>Richard Haxton Pt. #1 Box 65, Boys, Md.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>2504</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i> <i>Generalized arteriosclerosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> <i>4 yrs.</i> <i>5 yrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>260X</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
2d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>8-25</i> , 19 <i>64</i> , to <i>12-27</i> , 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12-27</i> , 19 <i>65</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <i>5:35 PM</i>					
22b. SIGNATURE <i>Howard J. Morre</i>		22c. DATE SIGNED <i>12-27-68</i>		22d. PHYSICIAN'S NAME (Type) <i>Howard J. Morre</i>	
22e. ADDRESS <i>7030 Carroll Ave., Takoma Park, Md.</i>					
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-31-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cem.</i>	
23d. LOCATION (City or Town) <i>Hyattsville Pr. Georges, Md.</i>		23e. ADDRESS <i>Sil. Spr., Md.</i>		23f. REC'D BY REG STRAR <i>JAN 3 1969</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey</i>		25b. REG STRAR'S SIGNATURE <i>Charles Judge</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17802

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17813

1 DECEASED-NAME (Type or print) First Middle Last <b>MARY E. MAYDEN</b>			2a DATE OF DEATH Month Day Year <b>DECEMBER 29, 1968</b>			2b HOUR P <b>1:05 PM</b>				
3 SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5 DATE OF BIRTH <b>June 25, 1899</b>		6 AGE (in years last birthday) <b>69 YRS</b>		7 UNDER YEAR MONTHS DAYS <b>11 UNDER 24 HRS HOURS MIN</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley N.H.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Montg.</b>		13c CITY OR TOWN <b>Rockville</b>		13d INSIDE CITY - N 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>257 Congressional Lane</b>	
14 FATHER'S NAME First Middle Last <b>Robert L. Dick</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth -- Muir</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b SOCIAL SECURITY NO. <b>577-03-3382B</b>		17. INFORMANT Address <b>Charles Hayden Son, Rockville, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic carcinoma, brain, lungs, liver, etc.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Primary carcinoma, gallbladder</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>---</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>---</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>---</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. <b>---</b>		21f. LOCATION Street or RFD No City or Town County State <b>---</b>						
22a I certify that (I) (the hospital) attended the deceased from <b>July 14, 1952</b> to <b>Dec. 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE <b>Warren D Brill, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Dec 29, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>WARREN D. BRILL, M.D.</b>				22e ADDRESS <b>2601 16th St. N. W. Wash. D. C. 20009</b>						
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12/31/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, 5130 Wis. Ave, NW, Wash, DC</b>				25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17814

1 DECEASED NAME (Type or Print) <u>Stygmester</u>		Middle		Last <u>Hebron</u>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST- MATED <input type="checkbox"/> <u>12-12</u> 19 <u>68</u> 10 <sup>05</sup> M		2b HOUR	
3 SEX <u>M.</u>	4 RACE <u>Negro</u>	5 DATE OF BIRTH <u>Oct 1, 1917</u>	6 AGE (In years last birthday) <u>51</u> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month <u>Dec</u> Day <u>12</u> Year <u>1968</u> 10 <sup>25</sup> M		2d HOUR	
7a BIRTHPLACE (State or foreign country) <u> Md. </u>		7b CITIZEN OF WHAT COUNTRY? <u> U.S. A </u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>		Md	
10 CITY OR TOWN OF DEATH <u>Clarksburg</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u> Md. </u>		13b. COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Clarksburg</u>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14. FATHER'S NAME First <u>Robert</u> Middle <u>Hebron</u> Last <u>Hebron</u>		15. MOTHER'S MAIDEN NAME First <u>Melinda</u> Middle <u>Payne</u> Last <u>Payne</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Madelaine Hawkins DAMASCUS Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending/ Pulmonary emboli - Acute</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocarditis, Acute &amp; chronic</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>1 hr. ?</u> <u>Weeks ?</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>431X</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John N. Bell</u> MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <u>12/12/68</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-18-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elijah Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Poolesville Montg Md.</u>			
24. FUNERAL DIRECTOR <u>Robert L. Snowden Rockville Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1994

VR A15 (4)  
30M REV. 1/68

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at the only event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Marcus			B		Hine	12 Month 10 Day 68 Year			12 <sup>55</sup> A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		6/21/00		68 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D.C.		U.S.A.				Montgomery Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hosp.				Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
DC		13b COUNTY		Takoma Park				223 Cedar Street	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John					Hine	Jean			Ellen Gruchey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
No						Mrs. Edna E. Hine, 223 Cedar St NW DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Carcinomatosis									3 mo
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lung									18 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Pulmonary emphysema - advanced									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (1) (this hospital) attended the deceased from June 1967, to Dec 9, 1968, that (1) (we) lost saw the deceased alive on Dec 9, 1968, and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
James R. Coleman M.D.									Dec. 10, 1968
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
JAMES R. COLEMAN					9241 COLUMBIA BLVD SILVER SPRING MARYLAND.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Dec. 13, 1968		National Memorial Park		Falls Church			VA
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
J. Arthur Walters, 254 Carroll St NW Wash DC							DATE DEC 12 1968		John Charles Judge

MEDICAL CERTIFICATE ON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 6 FilmG4C8 1/10/69 ts										
17817										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR a		
GARCIA			HINEBAUGH			12 Month 23 Day 68 Year		5:45 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
FEMALE		CAUS.		10-31-1879		88 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
OAKLAND, MD.		U. S. A.				MONT. COUNTY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
WHEATON			UNIVERSITY NURSINGH.			WAITRESS		Rest.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
9523 WEST - KENS			MONT.		KENSINGTON				9523 W. Stanhope Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Edward H. Bartlett			Elizabeth Fairell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT				
No			217-18-4832			Helen McIntire Kensington, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>									1 week	
4179 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>									?	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<i>Cerebral Thrombosis &amp; Arteriosclerosis</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , 19 <i>1966</i> , to <i>present</i> , 19 <i>1966</i> , that (I) (we) lost saw the deceased alive on <i>Dec 5</i> , 19 <i>1966</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dr. George M. ...</i>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/26/68		Oakland Cemetery		Oakland Maryland				
24. FUNERAL DIRECTOR <i>Gerald N. Winnick</i>				ADDRESS <i>Oakland, Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 31 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



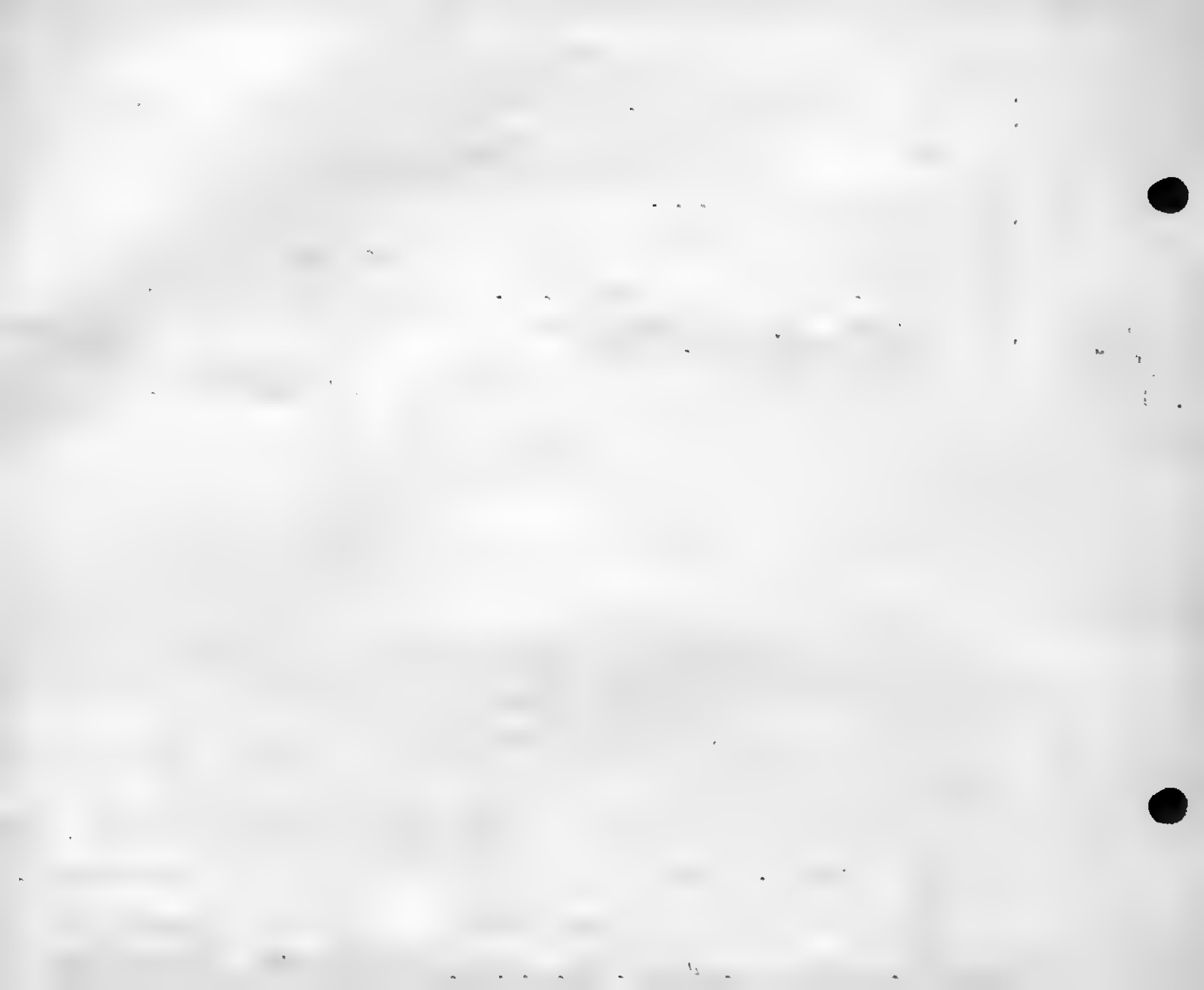


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner Dr. Belden R. Reap M.D.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Marguerite			A.		Holder	December 5 1968			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		7c. UNDER 1 YEAR MONTHS DAYS	
Female		White		January 5, 1908		60 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Minnesota		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		7411 Hancock Avenue		Housewife		own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Montgomery		Dk. Pk.				7411 Hancock Avenue	
14 FATHER'S NAME		14b. MOTHER'S MAIDEN NAME		15. INFORMANT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
Robert		Brooklyn		Henry Holder		No		yes	
17. DATE OF OPERATION		17b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None		None							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1964</u> to <u>Dec 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 5 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
		Ralph P. Patten		December 5, 1968		Ralph P. Patten		1407 Woodside Parkway Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-9-1968		Parklawn Cemetery		Rockville Montgomery, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE			
J.W. Lee		DEC 12 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17898											
Item 1, birth cert. in this Div. CERTIFICATE OF DEATH 17819											
1 DECEASED-NAME (Type or print) <b>CONRAD</b> First <b>CHRISTOPHER</b> Middle <b>BOY</b> Last <b>HOLSOMBACK</b>						2a. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>68</b>		2b. HOUR <b>1208</b> P <b>M</b>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>November 30, 1968</b>		6. AGE (In years last birthday) YRS. <b>1</b> MONTHS <b>13</b> DAYS <b>59</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) <b>Bethesda, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm'ss on) STATE <b>Maryland</b>		13b. COUNTY <b>Manassas</b>		13c. CITY OR TOWN <b>Manassas</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>113 Appomattox Ave.</b>			
14 FATHER'S NAME First <b>Conrad</b> Middle <b>Oliver</b> Last <b>Holsomback</b>				15 MOTHER'S MAIDEN NAME First <b>Patricia</b> Middle <b>Ann</b> Last <b>Patten</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>N/A</b>		16b. SOCIAL SECURITY NO <b>N/A</b>		17 INFORMANT <b>Mr. Conrad O. Holsomback, 113 Appomattox Ave.</b>		Address <b>Manassas, Va.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Bilateral atelectasis associated with prematurity</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
7625											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>A.M.</b> Month <b>Nov.</b> Day <b>30</b> Year <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. <b>Nov. 30, 1968</b>		City or Town <b>Dec. 2, 1968</b>		County <b>Montgomery</b>		State <b>Md</b>	
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Nov. 30, 1968</b> , to <b>Dec. 2, 1968</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Dec. 2, 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) <b>(did not)</b> view the body after death.											
22b. SIGNATURE <b>B. J. Bortz, M.D.</b>		DEGREE <b>LCDR, MCJ, USN</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <b>B. J. Bortz, M.D.</b>		22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3 Dec. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Naval Medical School</b>		23d. LOCATION (City or Town) <b>NINMC, Bethesda</b>		(County) <b>Montgomery</b>		(State) <b>Md</b>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles, Judge</b>					

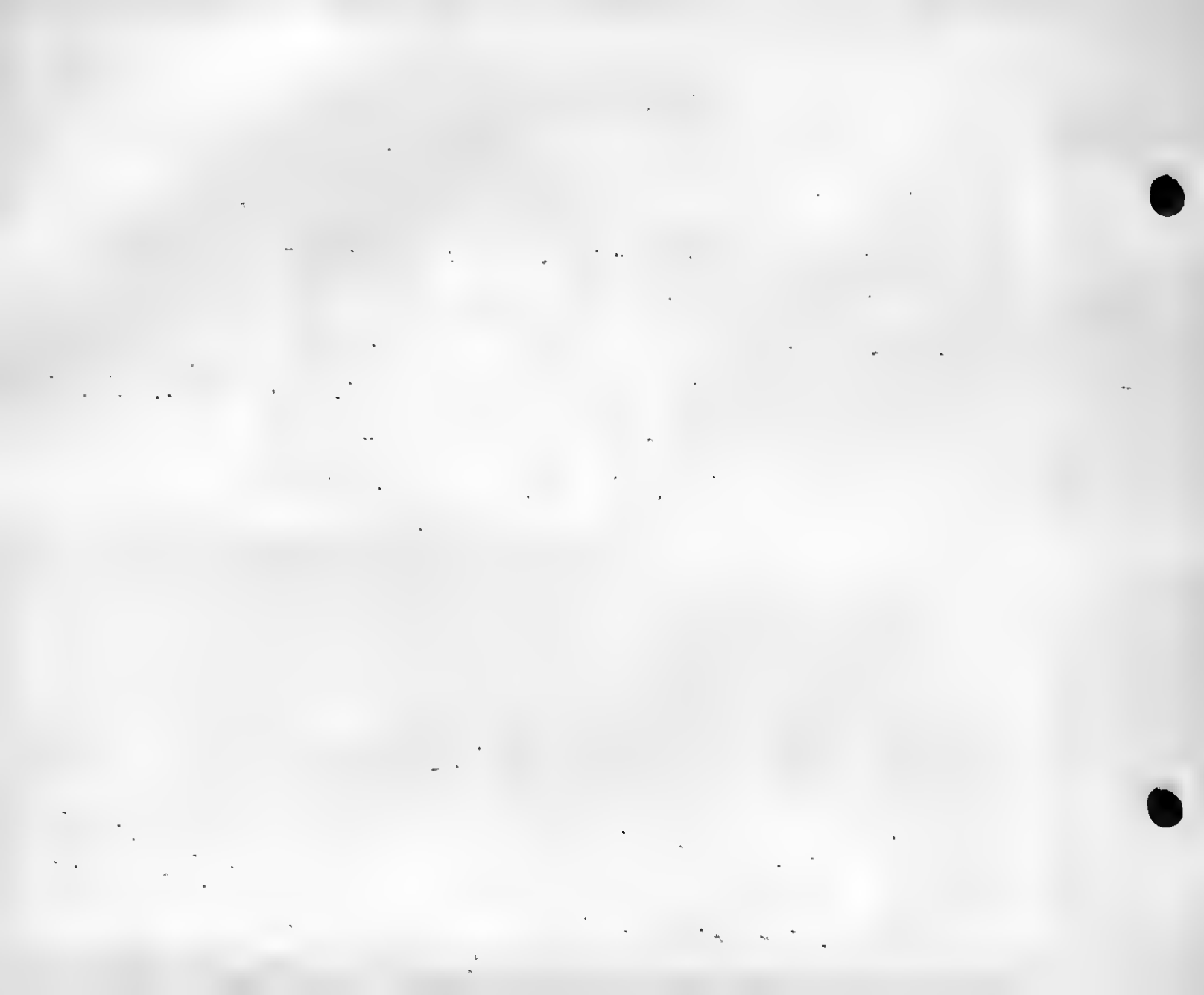


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
MARGARET			Greely HORTON			12 - 9 - 68			40 AM			
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Female		white		11-6-87			81 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Brownburg INDIANA		USA				MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING			CHRYSE CHASE CONV CENTER			Clerical - U.S. Government						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD			MONTGOMERY			SILVER SPRING		YES		8811 Coleville Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
PETER GREELY			MARGARET DUGAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			59-60-6719T			Miss Katherine B. Greely			15 Conn. Hve. Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cerebral hemorrhage										24 hours		
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerosis - generalized										5 years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
231x												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1966, to Dec 9, 1968, that (I) (we) saw the deceased alive on Dec 8, 1968, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED									
HARRY N. CARLTON MD			12/9/68									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
HARRY N. CARLTON			8811 Coleville Rd, S.S. Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Dec 12 1968			Mt. Olivet			Washington, D.C.			
24. FUNERAL DIRECTOR			24a. ADDRESS			24b. REGISTRAR'S SIGNATURE						
Warner E. Pumphrey, Inc.			243 Georgia Avenue Silver Spring, Md.			DEC 12 1968			Charles Judge			

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Charles E. HOWELL						Month Day Year		1968 1000	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	Cauc	Aug. 31, 1943	25 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year 1968 1000	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Texas		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Army			
13a. U.S.A. RESIDENCE (Where deceased lived, if admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Texas						Houston		1602 Antonine Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
E. V. Howell			Vernice Estelle Hearn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
ACTIVE DUTY			UNKNOWN		EV. HOWELL		1602 ANTONINE ST HOUSTON, TEXAS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral lacerations associated with multi-le									
DUE TO, OR AS A CONSEQUENCE OF skull fractures									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
				HOUR A.M. 30 P.M. Dec. 19 68		Passenger in Car. went out of control			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
		Street		4 or 5 miles south Fredricksburg on Route 17					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball, M. D.				ASS STANT MED. CA. EXAMINER <input type="checkbox"/>		Dec. 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		12-13-68		Woodlawn Cemetery		Houston			Texas
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
1400 Chapin St., N. W. Washington, D. C.						DATE DEC 20 1968		J Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copy of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17881

17822

1. DECEASED-NAME (Type or print) <b>Ms. Madeline A. Howell</b>			2a. DATE OF DEATH 12 Month 24 Day 68 Year			2b. HOUR 8:40 A.M.					
3 SEX <b>F.</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>10-15-1892</b>		6 AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Takoma Park, Mo.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanatorium-Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Beltville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>13233 Green mount Ave.</b>		
14. FATHER'S NAME First Middle Last <b>— — ACKER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>— — — — —</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>061-07-5313</b>		17. INFORMANT <b>Chub</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cerebro Vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis Generalized</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 17, 1968</b> to <b>24 Dec, 1968</b> , that (I) (we) last saw the deceased alive on <b>23 Dec 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas P. Fogarty</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>24 Dec 68</b>					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec 27-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>LA VY.</b>					
24. FUNERAL DIRECTOR <b>Charles Judge</b>				ADDRESS <b>257 Carroll St NW</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film 108 1/6/69 kk Items 18-22 Film 408 15810 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15823											
1. DECEASED NAME (Type or Print) LEON THOMAS HUBBARD						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12-30 1968			2b. HOUR 6:30 PM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 6-18-01	6 AGE (n years last birthday) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PROMOUNCED DEAD Month 12 Day 30 Year 1968			2d. HOUR 7:30 PM		
7a. BIRTHPLACE (State or foreign country) Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INST (If not in hospital give street address) Norbeck Road			12a. USUAL OCCUPATION (Kind of work done during usual of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE D.C.			13b. COUNTY Mont.			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 1501 Grandview Ave.											
14. FATHER'S NAME First Middle Last Hartford Hubbard				15. MOTHER'S MAIDEN NAME First Middle Last Hattie Mae (?)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes				16b. SOCIAL SECURITY NO. 229-34-6233				17. INFORMANT Joel D Hubbard			
				ADDRESS 11721 Valley Rd Fairfax VA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conflagration burns, 2nd and 3rd degree, 758X DUE TO, OR AS A CONSEQUENCE OF (b) entire body, self-inflicted DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 6:00 PM 12-30 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Deceased poured kerosene over himself and set himself afire.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm		21f. LOCATION Street or R.F.D. No Silver Spring		City or Town Montgomery		County Md.		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Peep		M.D. Belden R. Peep, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED DEC. 31, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE December 31		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) Blacksburg Rd. Annapolis, Md.		County Anne Arundel		State Md.	
24. FUNERAL DIRECTOR A. Arthur Walters				ADDRESS 254 Carroll St NW Wash. D.C.				25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17813		CERTIFICATE OF DEATH						17824	
1. DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR			
Frank L. Hungerford			DEC 20 1968			11 A M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE	White	1-13-00		68 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Nebraska	U.S.A.			Montgomery Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if related)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy cross Hospital		School Teacher		Teaching			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
md.		Montgomery		Silver Sp.				515 Thayer Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Walter -- Hungerford			Ada C. Gwin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		223-48-7394		Mrs. Cecile Hungerford		515 Thayer Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Status post-op craniotomy for									
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) (b) Glioblastoma Multiforme, right frontal lobe. 91X									
DUE TO, OR AS A CONSEQUENCE OF (a) Pulmonary embolism & complete occlusion									
DUE TO, OR AS A CONSEQUENCE OF (c) occlusion of right pulmonary artery.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
12/20/68		S-cere 18.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1965, to 12/28, 1968, that (I) (we) last saw the deceased alive on 12/28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
G. Lennard Gold						12/28/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
G. Lennard Gold, M.D.		9801 Georgia Ave., S.S., Md. 20902							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-2-1969		Cedar Grove Cemetery		Mt. Morris, Pennsylvania			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.		8434 Georgia Ave.		JAN 3 1969		Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Item 2a File # 17825 1/15/69 kkl DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17825

1 DECEASED NAME (Type or Print) <i>Edward Scott Hunter</i>			2a DATE KNOWN OF EST. DEATH <i>12 28 1968</i>			2b HOUR M <i>3P</i>		
3 SEX <i>M</i>			4 RACE <i>W</i>			5 DATE OF BIRTH <i>5-30-1949</i>		
6 AGE (In years last birthday) <i>19</i> YRS			7 IF JUNIOR 1 YEAR MONTHS <i>6</i> DAYS <i>28</i>			8 IF JUNIOR 24 HRS HOURS <i>6</i> MIN <i>28</i>		
7a BIRTHPLACE (State or foreign country) <i>Md.</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Sheet-Metal Wc</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>U.S. Govt</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Mont. Glen Echo</i>			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME <i>Richard Hunter</i>			15 MOTHER'S MAIDEN NAME <i>Beulah McCrossin</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service)		
16b SOCIAL SECURITY NO. <i>214-12-7591</i>			17 INFORMANT <i>Wife-Virginia</i>			ADDRESS <i>6421-78th St. Cabin, John, Md.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular Disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> <i>years.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>42.1</i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>Dec 28, 1968.</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <i>12-31-68</i>			23c NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		
23d LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>			24 FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>			25a REC'D BY REG STRA <i>JAN 9 1969</i>		
24 ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i>			25b REGISTRAR'S SIGNATURE <i>John G. Ball</i>					

100-1500 (5)  
100-1500-1-68





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-15. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Filed 12/16/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17826

1. DECEASED-NAME (Type or Print) <b>Joseph Hopkins Hurley</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>Dec</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>2:45 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>2-22-01</b>	6. AGE (in years last birthday) <b>67</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Dec</b> Day <b>4</b> Year <b>1968</b>
7a. BIRTH-PLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash San &amp; Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>lawyer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Takoma Pk</b>	13d. INSIDE CITY, UNITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>26 Philadelphia Ave</b>	
14. FATHER'S NAME First <b>Peter</b> Middle <b>Hurley</b> Last <b>Hurley</b>			15. MOTHER'S MAIDEN NAME First <b>Ellen</b> Middle <b></b> Last <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>wife</b>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Essential Hypertension</b>						
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>BELDEN K. DEAPMD</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>DEC 4 1968</b>
EXAMINER'S NAME (Type)		ADDRESS Street city, town, or county		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<b>Burial</b>	<b>Dec. 7, 1968</b>	<b>Mount Carmel Cemetery</b>		<b>Washington D.C.</b>		
24. FUNERAL DIRECTOR <b>Arthur Walter</b>		ADDRESS <b>254 Carroll Ave. Wash DC</b>		25a. REC'D BY REGISTRAR <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jager</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <b>CAROLYN R. IRISH</b>						2a DATE OF DEATH Month <b>DECEMBER</b> Day <b>28</b> Year <b>1968</b>			2b HOUR <b>11:15 P.M.</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Feb. 5, 1895</b>		6 AGE (In years last birthday) <b>73</b> YRS.		7 UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>15</b>		8 UNDER 24 HRS HOURS <b>11</b> MIN <b>15</b>	
7a BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md					
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley Nursing Home</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Metallurgist</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>		13b COUNTY <b>Montg.</b>		13c CITY OR TOWN <b>SILVER SPRING</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>3563 So. LEISURE WORLD BLVD.</b>			
14 FATHER'S NAME First <b>Edward</b> Middle <b>Moss</b> Last <b>Ring</b>				15 MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>--</b> Last <b>Schiesbury</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <b>579-22-9763</b>				16c INFORMANT <b>John G. Jarlee 3114 Spring Drive, Alex., Va.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>leiomyosarcoma c metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>to lung, bone &amp; lymph nodes</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>last</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/12/68</b> to <b>12/28/68</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/28/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Henry C. Scruggs MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>12/29/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>HENRY C. SCRUGGS MD</b>				22e ADDRESS <b>5413 Cedar Lane Bethesda Md.</b>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>1-2-1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemet.</b>		23d LOCATION (City or Town) <b>Baltimore</b>		(County) <b>Maryland</b>		(State)	
24 FUNERAL DIRECTOR <b>C. Glen Carter</b>				ADDRESS <b>Sil. Spr., Md.</b>		25a REC'D BY REGISTRAR <b>JAN 6 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Snagge</b>			
26 FUNERAL HOME <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17817

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17828

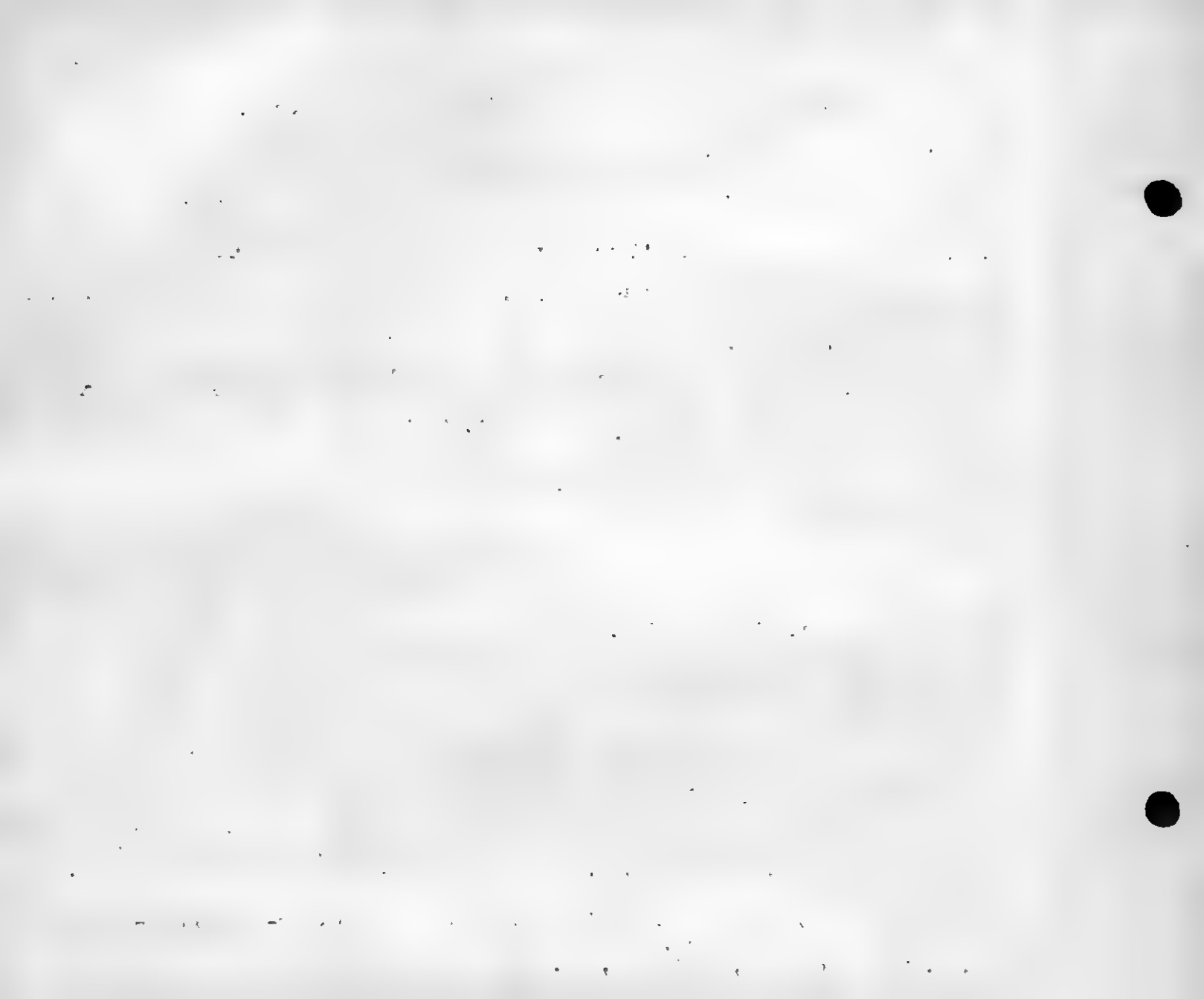
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Oliver John Irish						December 7 1968			8:45 PM		
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male	Caucasian		April 2, 1902			76					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Iowa		U. S. A.				Montgomery Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Olney			Montgomery General Hospital Biochemist			Medical Lab					
13a USUAL RESIDENCE (Where deceased admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Montgomery		Silver Spring				3563 Leisure World Blvd.		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
George Berna Irish						Sarah Elizabeth Chapman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT					
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			U.S. 1 & 11			215-38-6461 Mrs. Carolyn Irish Silver Spring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>										5 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>										6 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION											
19b CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
21f LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>December 7, 1968</u> , that (I) (we) lost saw the deceased alive on <u>December 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE											
George N. Polis, M.D.											
22c DATE SIGNED											
December 8, 1968											
22d. PHYSICIAN'S NAME (Type)											
George N. Polis, M.D.											
22e ADDRESS											
1631 16th St., N.W., Wash., D.C.											
23a BURIAL, CREMATION OR REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial		Dec. 11, 1968		Baltimore National Cem.			Baltimore, Maryland				
Funeral Director		C. Glen Carter		8434 Georgia Ave.			Silver Spring, Md.				
VR A15 45M - 1		Warner E. Pumphrey, Inc.		25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
					DEC 12 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Edward	Middle Thawley	Last Jackson	2a. DATE OF DEATH Month December		Day 17,	Year 1968	2b HOUR P 11:30 AM
3. SEX Male		4 RACE White		5. DATE OF BIRTH. May 5, 1913		6 AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Usual: Truck Driver		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Frederick		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 133 South Market St. Apt. 2		
14 FATHER'S NAME			First Thomas	Middle E.	Last Jackson	15 MOTHER'S MAIDEN NAME			First Gertrude	Middle Houser
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 212-17-8461 Not available		17 INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Hemorrhagic infarction right PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebrum 4319 DUE TO, OR AS A CONSEQUENCE OF Carotid Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 1 Year APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Hours										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 222										
19a. DATE OF OPERATION 12/17/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Occlusive Carotid Atheroma			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from December 8, 1968, to December 17, 1968, that (A) (we) last saw the deceased alive on December 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.										
22b SIGNATURE Peter J. Deckers MD		DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 18 December 1968			
22d PHYSICIAN'S NAME (Type) Peter J. Deckers, M. D.		22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.								
23a BURIAL, CREMAT. OR BURNED (Type) Buried		23b DATE 12/21/68		23c NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d LOCATION (City or Town) (County) (State) Potomac-Montgomery-Maryland				
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701		25a REC'D BY REGISTRAR DATE DEC 23 1968			25b. REGISTRAR'S SIGNATURE Charles Gudge					





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 7/69

17830										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH										17830																
1 DECEASED NAME (Type or print)			First Fannibelle			Middle Adams			Last Jackson			2a DATE OF DEATH			Month 12			Day 10			Year 68			2b HOUR 2:05 PM		
3 SEX Female			4 RACE Caucasian			5 DATE OF BIRTH 1-20-1896			6 AGE (In years last birthday) 72			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS HOURS			MIN								
7a BIRTHPLACE (State or foreign country) Indiana			7b CITIZEN OF WHAT COUNTRY? United States			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery																	
10 CITY OR TOWN OF DEATH West Chevy Chase			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4848 Crescent St. West Chevy Chase, Maryland			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Secty.			12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.																	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN West Chevy Chase			13d HRS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 4848 Crescent Street														
14 FATHER'S NAME			First Jeremiah			Middle Adams			Last Haley			15. MOTHER'S MAIDEN NAME			First Haley			Middle Power			Last Power					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT Curtis A. Jackson, Husband, same as #13a.																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Ascending colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>1530</u>																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No City or Town County State																				
22a I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>Dec 10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-10-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death.																										
22b SIGNATURE <u>P.P. Andrews MD</u>			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <u>12-10-68</u>																	
22d PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u>			22e ADDRESS <u>WASHINGTON, DC 20016</u>																							
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>			23b DATE <u>12-13-1968</u>			23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d LOCATION (City or Town) (County) (State) <u>Rockville, Montgomery Co., Md.</u>																	
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave., N.W., Wash., D.C., 20016</u>			24b REC'D BY REGISTRAR <u>DEC 19 1968</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>																				



## CERTIFICATE OF DEATH

17830

17831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) <b>Bernard L. Johnson</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1968</b>		2b. HOUR <b>10:45</b> AM
3 SEX <b>MALE</b>	4. RACE <b>NEGROID</b>	5. DATE OF BIRTH <b>6-9-94</b>		6 AGE (In years last birthday) <b>74</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Montgomery County</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Georgetown School Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>8902 Perz Avenue Silver Spring MD</b>	13b. CITY <b>Silver Spring</b>	13c. CITY OR TOWN <b>MD</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER	
14. FATHER'S NAME <b>John Johnson</b>	15. MOTHER'S MAIDEN NAME <b>Mary ?</b>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>495X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rheumatoid arthritis</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh e at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)		21f. LOCATION Street or RFD No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>62</b> , to <b>12/17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/17</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Wiggon L. Gordon MD</b>	22c. DATE SIGNED <b>12/17/68</b>		22d. PHYSICIAN'S NAME (Type) <b>2309 SHOREFIELD RD WHEATON MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>12-21-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATES OF HEAVEN</b>		23d. LOCATION (City or Town) (County) (State) <b>ASPEN Hill Montg Md.</b>	
24. FUNERAL DIRECTOR <b>George K. Snowden</b>		25a. REC'D BY REGISTRAR <b>Rockville</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
178321					17832												
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print) <b>Eleanor</b>			First <b>Ella (Eleanor)</b>		Middle <b>M.</b>		Last <b>Johnson</b>		2a. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>1968</b>		2b. HOUR <b>3:20P</b> M						
3. SEX <b>Female</b>			4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 9, 1887</b>			6. AGE (In years last birthday) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md									
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2029 Lanier Drive</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Sil. Spr.</b>		3a. INS DE CITY LIMTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2029 Lanier Drive</b>							
14. FATHER'S NAME <b>Thomas</b>			First <b>—</b>		Middle <b>—</b>		Last <b>Kennedy</b>		15. MOTHER'S MAIDEN NAME <b>Laura</b>			First <b>—</b>		Middle <b>—</b>		Last <b>Miller</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b>			16b. SOCIAL SECURITY NO <b>472-52-5659</b>			17. INFORMANT <b>Dorothy J. Carlton</b>			Address <b>Sil. Spr. Md.</b> <b>2029 Lanier Drive</b>								
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Disease</b> <b>4-7</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic Myocardial Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> <b>3-4</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>3 hrs</b> <b>7 hrs</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>None</b>																	
19a. DATE OF OPERATION <b>4-2-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street factory, office building etc)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>May 15, 1966</b> to <b>Dec 1, 1968</b> that (I) <b>(two)</b> last saw the deceased alive on <b>Nov 22, 1968</b> , and that in (my) <b>(four)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(two)</b> <b>(did)</b> <b>(did not)</b> view the body after death																	
22b. SIGNATURE <b>John S. Rogers, M.D.</b>								DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-2-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>John S. Rogers, M.D.</b>								22e. ADDRESS <b>1919 Seminary Road, Sil. Spr. Md.</b>									
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>			23b. DATE <b>12-2-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Crematory</b>			23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Maryland</b>									
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>			M.A. Dwall <b>8434 Georgia Avenue</b>		ADDRESS <b>Sil. Spr. Md.</b>			25a. REC'D BY REGISTRAR <b>DEC 5 1968</b>		25b. REC'D BY REGISTRAR <b>DEC 5 1968</b>							



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 407  
12-23-68 am

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17833

1 DECEASED NAME (Type or Print) <b>ROBERT DANIEL JONES</b>			2a DATE KNOWN OF EST. <input checked="" type="checkbox"/> Month Day Year DEATH MATED <input type="checkbox"/> 12-1-1968			2b HOUR 5:40 A.M.				
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>7-3-12</b>	6 AGE (In years last birthday) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 12 Day 1 Year 1968			2d HOUR 5:40 A.M.	
7a BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md				
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospito. give street address) <b>Holy Cross Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Management</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Insurande</b>		
13a USUAL RESIDENCE (Where deceased lived, if institut on- admission) STATE <b>Md.</b>			13b COUNTY <b>Mont.</b>		13c CITY OR TOWN <b>S.S.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>2029 Hanover St.</b>
14. FATHER'S NAME First Middle Last <b>Frank O'Donaghue</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Susannah --- Rooney</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO (if yes give war or dates of service) <b>298-05-8746</b>		17. INFORMANT ADDRESS <b>Hercelia Jones, 2029 Hanover St., S.S., Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4001</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>BELOEN R. REAP</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>DEC. 2, 1968</b>		
EXAMINER'S NAME (Type) <b>BELOEN R. REAP</b> M.D.		ADDRESS <b>Silver Spring, Md.</b>		CITY OR TOWN <b>Silver Spring</b>		COUNTY <b>Montgomery</b>		STATE <b>Md.</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12-4-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Silver Spring Montgomery Md.</b>				
24 FUNERAL DIRECTOR <b>M. Andrew Duwall</b> <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>				ADDRESS <b>Sil. Spr. Md.</b>		25. REC'D BY REGISTRAR DATE <b>DEC 6 1968</b>		25b. EXAMINER'S SIGNATURE <b>[Signature]</b>		





## CERTIFICATE OF DEATH

17833

17834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>Angelita Villonco Katigbak</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>8:05 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Filipino</b>		5. DATE OF BIRTH <b>30 July 1953</b>		6. AGE (in years lost birthday) <b>15</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Philippines</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Philippines</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE <b>Philippines</b>		13b. COUNTY <b>Makati, Rizal</b>		13c. CITY OR TOWN <b>Makati, Rizal</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>25 Narra Avenue, Forbes/Park</b>	
14. FATHER'S NAME First <b>Arturo</b> Middle <b>Katigbak</b> Last <b>Nelly</b>			15. MOTHER'S MAIDEN NAME First <b>Nelly</b> Middle <b>Villonco</b> Last <b>Villonco</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, NIH, Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>E. coli septicemia</b> <b>2040</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute lymphocytic Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>11 Months</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>11</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>Oct. 14</b> , 19 <b>68</b> , to <b>Dec. 9</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>December 9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>David H. Riddick, Md.</b>		22c. DATE SIGNED <b>10 December 1968</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>14 Dec. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MANILA PHILIPPINES</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>RINALDI FUNERAL HOME, 7400 GEORGIA AVE. N.W.</b>		ADDRESS <b>200 12</b>		25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17821										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
17835										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
Solomon			Kaufman			Month Day Year			12:25	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
male	white	7-3-96		72 YRS.		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Russia			USA					Montgomery		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park			San & Hospital			SALESMAN			SHOE	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		415 Silver Spring Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Wolf Kaufman			Diane XXXXX							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT					
Yes			219-07-1597		MRS. FANNYE LEIBOWITZ, 401 SPRING PLAZA APT. 306, 1001 SPRING ST. SILVER SPRING, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			DEC 8, 1968				
Belden R. Leaph			DEPUTY MEDICAL EXAMINER							
			ADDRESS (Street, City, Town, or County)							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		12-10-68		HAR ZION TIFRETH ISRAEL		ROSEDALE, MARYLAND				
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG STRAR		25b REG. STRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						DEC 10 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1, 2, and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 12-68  
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17825 CERTIFICATE OF DEATH 17836										
1 DECEASED NAME (Type or print)			First		Middle		Last		20. DATE OF DEATH	
R. HARRY KEARNEY, JR.									Month Day Year 12-29-1968	
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years lost birthday)	
Male			Caucasian			May 20, 1903			65 YRS	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Wash., DC			U.S.A.						Montgomery Md	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban Hospital			Ret-Auto Dealer			Auto	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY, IN 157	
Md.			Montg.			Bethesda			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
R. Harry Kearney			Ida -						Awkard	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address	
No			578-05-6358			R. Harry Kearney, III, Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral confluent Bronchopneumonia</u>										2 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>485X</u>										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Laennec's Keriosis - advanced.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			yes.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>July 57</u> , 19 <u>67</u> to <u>12/29</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>12/29</u> , 19 <u>68</u> , and that in ( <u>my</u> ) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death										
22b. SIGNATURE			22c. DATE SIGNED							
<u>J. Blaine Fitzgerald MD</u>			<u>12/30/68.</u>							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
<u>J. BLAINE FITZGERALD</u>			<u>8218 Wisc. Ave. Bethesda, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			12/31/68			Cedra Hill Cemetery			Suitland, Md.	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Jos. Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C.			DATE <u>JAN 3 1969</u>			<u>Charles Judge</u>				



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17837		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17837		
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF EST. DEATH		2b HOUR	
WILLIAM			HOWARD		KEITH				Month Day Year 12- 1 68		8:30 P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR				
Male	White	9-1-12	56 YRS			12 1 1968		8:30 P				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		United States				Montgomery						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Olney			Montgomery General Hospital			Electrician			Electrical			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland			Montgomery			Monrovia			Rt. 1, Box 178			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME									
Turner			Keith			Fannie			C. Burdette			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
YES No			214-18-5768			Admission Recd.			Montgomery Gen. Hospital, Olney			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Belden R. Neap</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type) <u>BELDEN R. NEAP M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>DEC. 2, 1968</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				Dec. 4, 1968				St. Michael's				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				
Olin L. Molesworth, Damascus, Md.								DATE DEC 5 1968				
								25b. REGISTRAR'S SIGNATURE <u>H. Clonney Judge</u>				

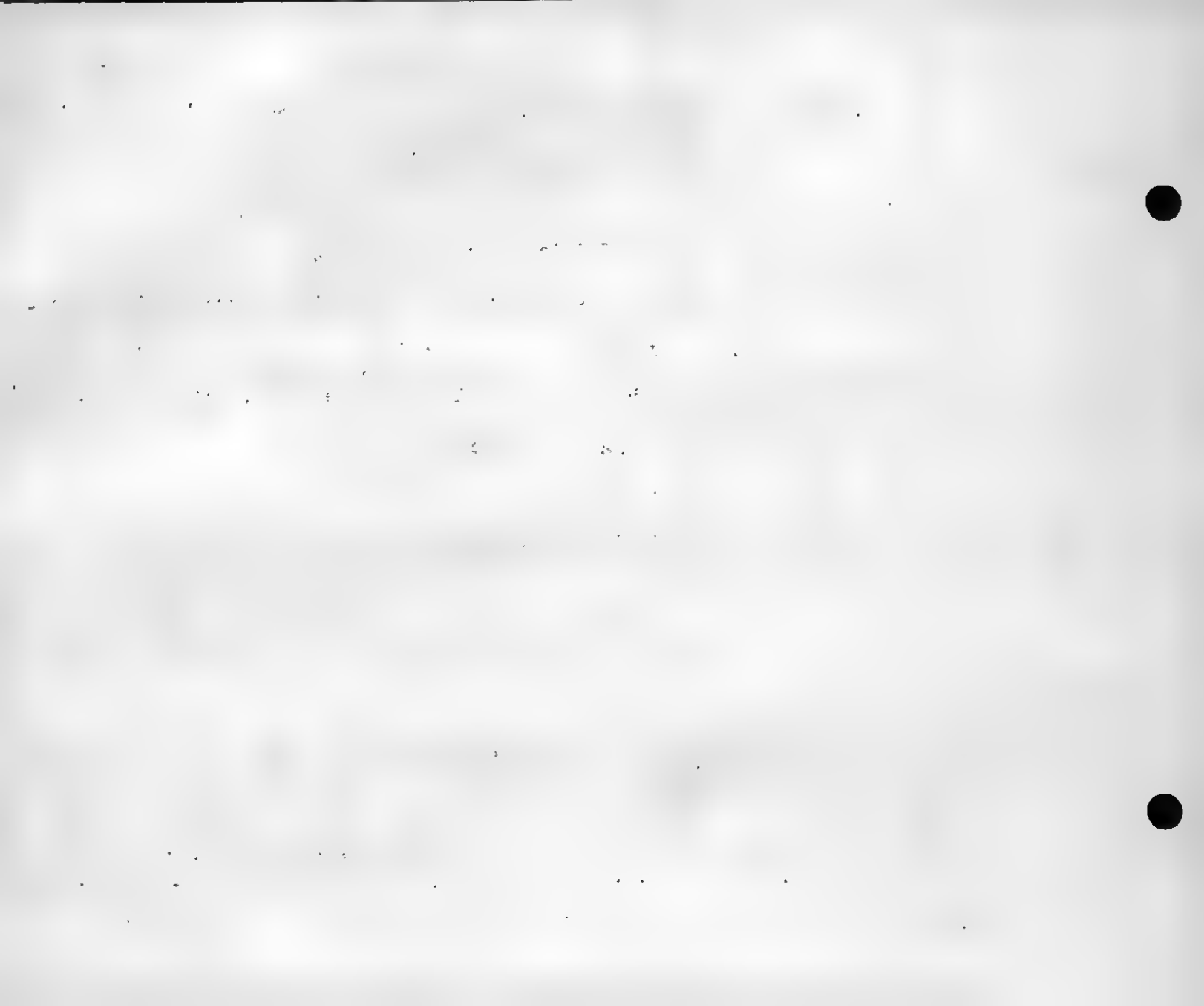




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>James Henry Kelley</b>						2a. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>1:00</b> MIN <b>A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9 June 1930</b>			6. AGE (In years last birthday) <b>38</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>The Clinical Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Draftsman</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Germantown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 193</b> <b>Cider Barrel Trailer Court</b>			
14. FATHER'S NAME First <b>Robert</b> Middle <b>S.</b> Last <b>Kelley</b>				15. MOTHER'S MAIDEN NAME First <b>Maida</b> Middle <b>Ethel</b> Last <b>Hartberger</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>226-32-8071</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, NIH, Bethesda, Md. 20014</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Gram negative septicemia</b> <b>7101</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septic arthritis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <b>Psoriatic arthritis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>days</b> <b>years</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3 December, 1968</b> , to <b>4 Dec.</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>4 December</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.												
22b. SIGNATURE <b>J.D. Gardner, M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-4-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Jerry D. Gardner, M.D.</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-8-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset View Memo. Gardens</b>				23d. LOCATION (City or Town) (County) (State) <b>Woodstock, Va.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Lee Fun. Home 300 4th St. NE Wash., D.C.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17839									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Mollie			KERNER			12 Month 27 Day 68 Year		11:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		9-1-99		69 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hosp. & C.		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER			
Wash. D.C.						1401 Whittier Pl. N.W.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JACOB			Rothman			Gittel Rothman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						Robert Kent 6923 Neathurst Rd. Beth. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA								5 HOURS	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) ACUTE MYOCARDIAL INFARCTION								5 HOURS	
DUE TO, OR AS A CONSEQUENCE OF									
(c) ACUTE "FLU" SYNDROME								1 WEEK	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/13, 1963, to 12/27, 1968, that (I) (we) last saw the deceased alive on 12/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Henry R. Wolfe M.D.		12/2							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
HENRY R. WOLFE M.D.		1131 UNIVERSITY BLVD. W., S.S. MD. 20902							
23a. SURGICAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		12/29/68		King David Mem. Garden		Falls Church Va.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Bernard Dargatzis & Sons 5001 14th St N.W. Wash. D.C.		JAN 2 1969		Charles Judge					

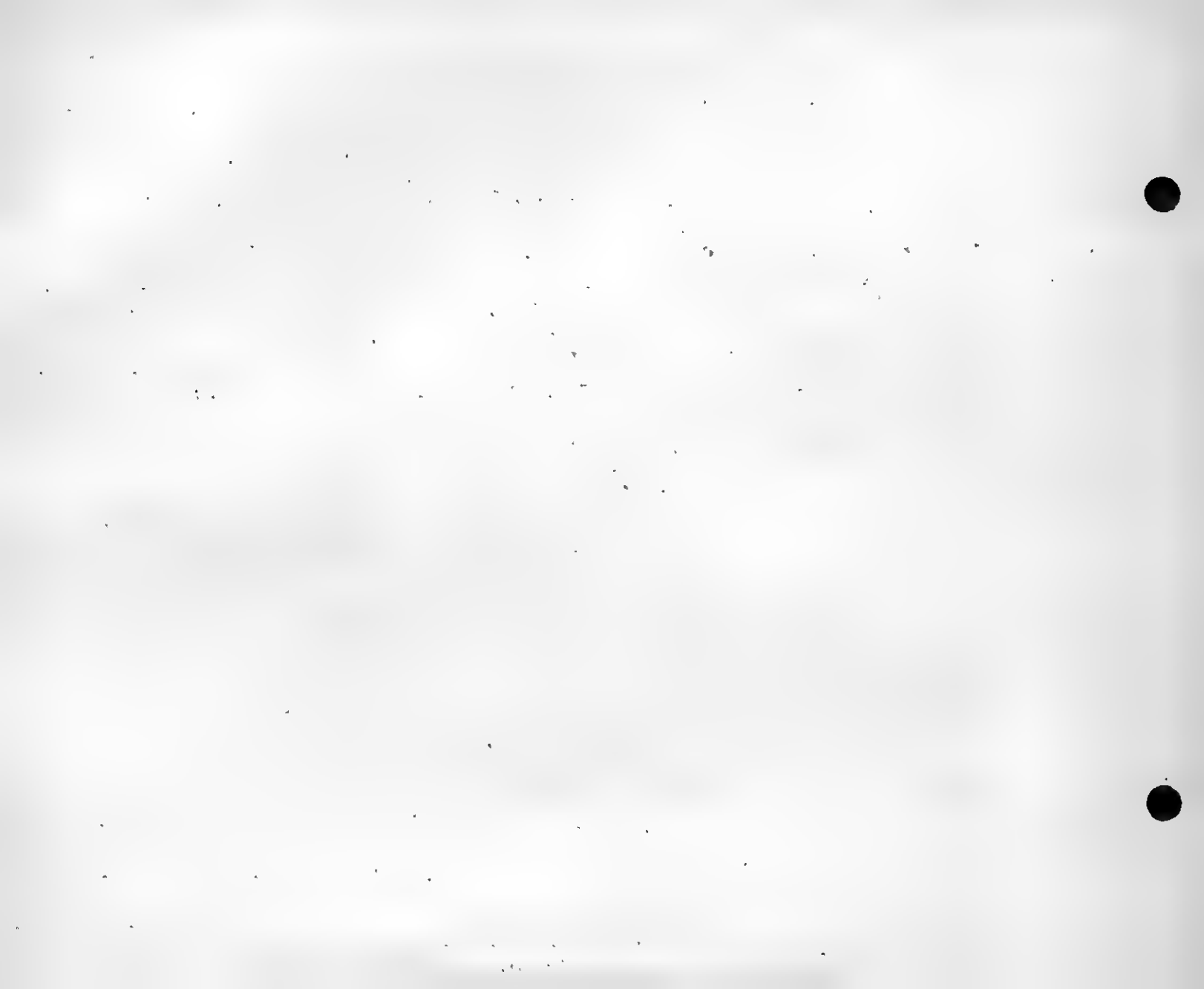


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VR A1574  
30M REV. 3/68

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <i>Andrew J. Kessinger</i>						2a. DATE OF DEATH Month Day Year <i>12 3 68</i>			2b. HOUR <i>3:30 AM</i>		
3 SEX <i>M</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>4/22/78</i>		6 AGE (In years last birthday) <i>90</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Missouri</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED TO NEVER MARRIED <i>WIDOWED</i>		9 COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Colonial Villa Nursing Home</i>				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Real Estate</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>builder</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Kensington</i>		3a INS-OR (NY LIMITS) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>3333 University Blvd. W.</i>			
14. FATHER'S NAME First Middle Last <i>Francis M. Kessinger</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>(Unknown)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>--</i>		16b SOCIAL SECURITY NO <i>214-03-9843 A</i>		17 INFORMANT <i>Jackson A. Kessinger</i>				Address <i>Sil. Spr. Md. 700 Nottley Road</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i>										<i>74 yr.</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Old Colon</i>										<i>204 yr</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased, from <i>June 3, 1946</i> , to <i>Dec 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>3:30 AM 12/3/68</i>											
22b. SIGNATURE <i>LOP Wardrop MD</i>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/3/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. Wm. B. Wardrop</i>						22e. ADDRESS <i>800 Pershing Drive, Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-6-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montgomery Md.</i>		23e. REGISTRAR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>			
23f. REGISTRAR <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>						23g. REC'D BY REGISTRAR <i>DEC 6 1968</i>		23h. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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1  
 17830  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 CERTIFICATE OF DEATH  
 17841  
 1  
 17830  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 CERTIFICATE OF DEATH  
 17841

1 DECEASED NAME (Type or print) <b>Lyle</b>		First <b>M.</b>	Middle <b>--</b>	Last <b>Kincheloe</b>	2a. DATE OF DEATH Month <b>Dec.</b> Day <b>15</b> Year <b>1968</b>		2b. HOUR <b>11:30 AM</b>
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>December 27, 1900</b>		6 AGE (In years last birthday) <b>67</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Tennessee</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>	
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>118 Normandy Drive</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Linotype Operator</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Sil. Spr.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Robert</b> Middle <b>Lyons</b> Last <b>Kincheloe</b>		15. MOTHER'S MAIDEN NAME First <b>Florence</b> Middle <b>S.</b> Last <b>Keen</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			
16b. SOCIAL SECURITY NO <b>4001</b>		17 INFORMANT Address <b>Sil. Spr. Md.</b> <b>Miss Mildred Kincheloe 118 Normandy Drive</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4:15 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4:15</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/10/65</b> 19, to <b>12/19/68</b> 19, that (I) (we) last saw the deceased alive on <b>12/13/68</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John J. Curry M.D.</b>		22c. DATE SIGNED <b>12/15/68</b>		22d. PHYSICIAN'S NAME (Type) <b>John J. Curry, M.D.</b>			
22e. ADDRESS <b>9801 Georgia Avenue, Silver Spring, Md.</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-17-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		24a. ADDRESS <b>Sil. Spr., Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



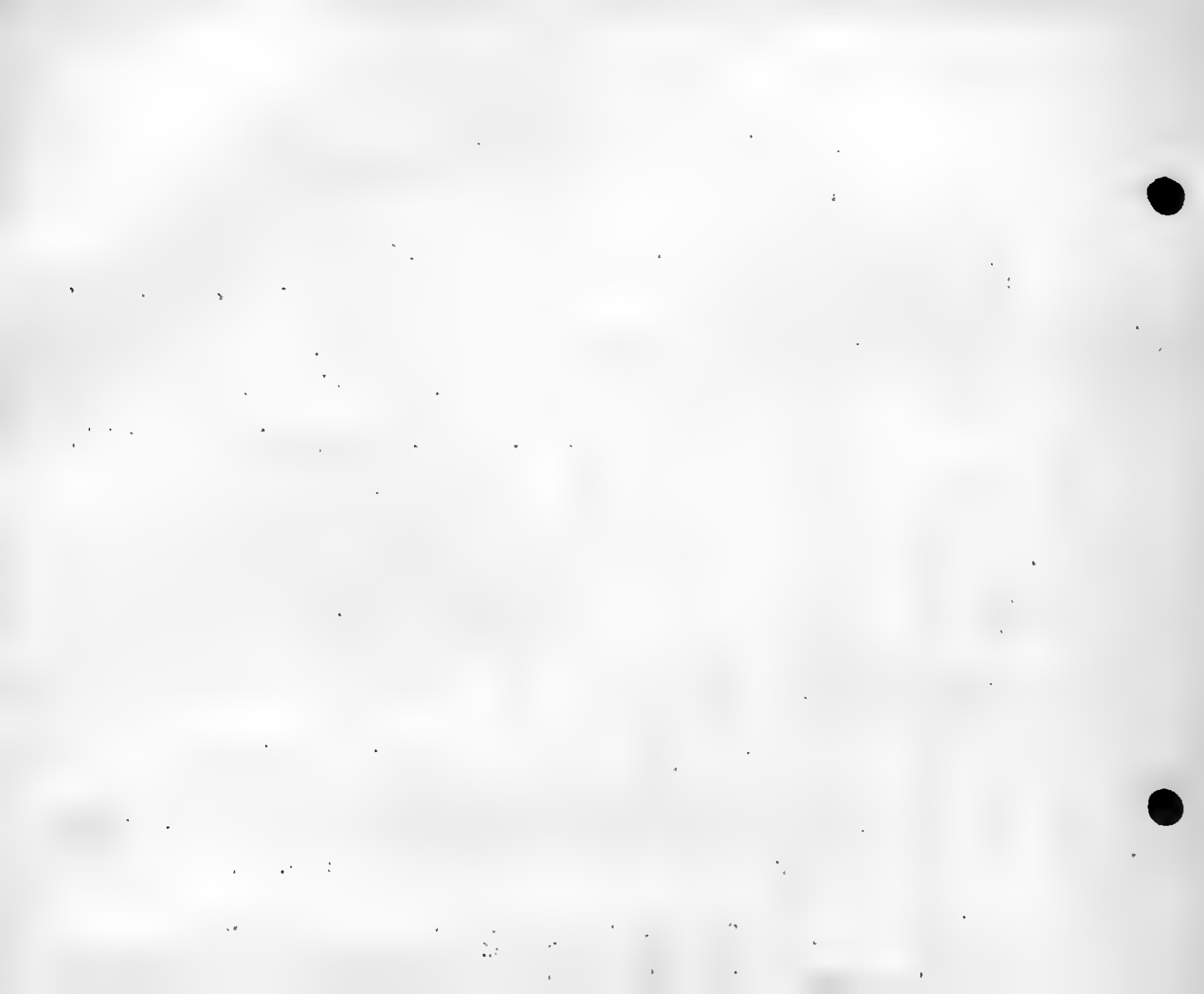


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared By Medical Examiner

17841		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17842	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print) First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR	
Aina S. Finefick			12-17-48			12 P-M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)	
Female		Caucasian		12-28-88		79 YRS.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
New York		U. S.		Frontgomery Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Haley Cross		Retired Teacher			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Wash. 241						13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last					
Michael Hayden		Katherine Keyes					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
no		579-66-2483		Hospital Records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 MYOCARDIAL INFARCTION						3 Days	
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS						?	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
T2L							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 1948 to 12/17/68, that (I) (we) lost the deceased alive on 16 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE William D. Aud		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 12/17/68	
22d PHYSICIAN'S NAME (Type)		WILLIAM D. AUD		22e ADDRESS 9006 COLESVILLE ROAD SIL. SP. MD.			
23a BURIAL, CREMATION, or other (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
BURIAL		12-19-68		MT OLIVET CEMETERY		WASHINGTON D. C.	
24 FUNERAL DIRECTOR COLLINS FUNERAL HOME ADDRESS 500 University Blvd. W. SILVER SPRING, MD.				25a REC'D BY REGISTRAR DATE DEC 20 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 45M - 1068

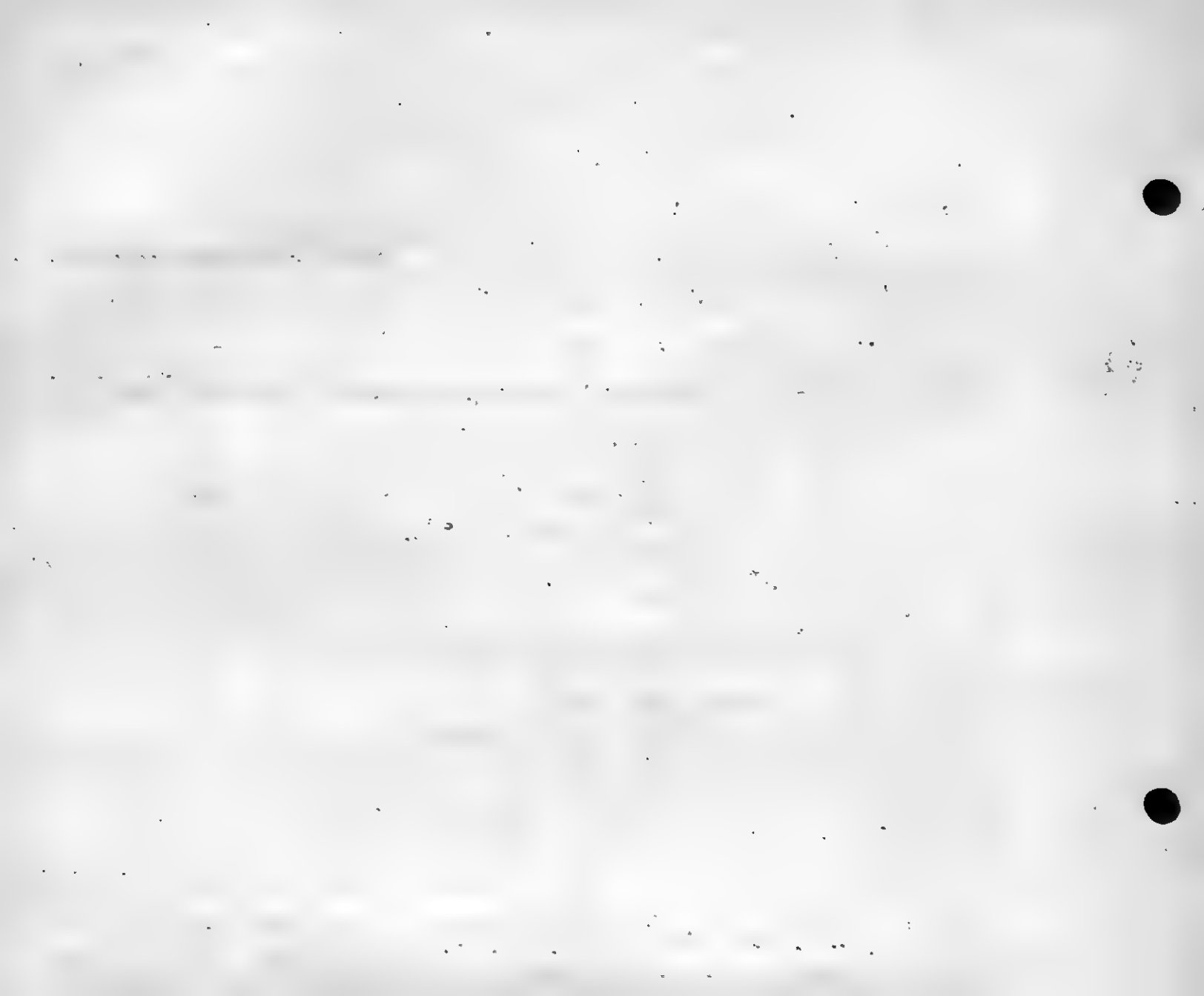
17802		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17843			
1 DECEASED NAME (Type or print) <sup>First</sup> <i>Dorothea</i> <sup>Middle</sup> <i>R.</i> <sup>Last</sup> <i>Kinsey</i>						2a. DATE OF DEATH <sup>Month</sup> <i>12</i> - <sup>Day</sup> <i>19</i> - <sup>Year</sup> <i>68</i>		2b. HOUR <i>6:18 P.M.</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-8-12</i>		6. AGE (In years last birthday) <i>56</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Waitress</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>435 E. Diamond Street</i>	
14. FATHER'S NAME <sup>First</sup> <i>Charles</i> <sup>Middle</sup> <i>Ran</i> <sup>Last</sup> <i>Smith</i>		15. MOTHER'S MAIDEN NAME <sup>First</sup> <i>Nellie</i> <sup>Middle</sup> <i>Smith</i> <sup>Last</sup> <i>Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>215-14-7438</i>		17. INFORMANT <i>Buddy B. Kinsey</i>		Address <i>1607 Marshall Rd. Rockville Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>+107</i> DUE TO, OR AS A CONSEQUENCE OF Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4201</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i> <i>48 hours</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Sub</i> <i>Acute yellow atrophy, liver &amp; renal failure secondary to above.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY <sup>HOUR A.M.</sup> <sup>Month</sup> <sup>Day</sup> <sup>Year</sup> <i>19</i> <i>P.M.</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION <sup>Street or R.F.D. No.</sup> <sup>City or Town</sup> <sup>County</sup> <sup>State</sup>					
22a. I certify that (I) (this hospital) attended the deceased from <i>11 Dec</i> , 19 <i>68</i> , to <i>19 Dec</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>19 Dec</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederick S. Caldwell MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/20/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>FREDERICK S. CALDWELL</i>				22e. ADDRESS <i>Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12-23-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Rose Church</i>		23d. LOCATION (City or Town) <i>Gaithersburg</i> (County) <i>Montgomery</i> (State) <i>Md</i>			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS <i>Gaithersburg Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <b>MARTIN HENRY KINSINGER</b>						2a. DATE OF DEATH <b>12</b> Month <b>3</b> Day <b>68</b> Year			2b. HOUR <b>8</b> <sup>45</sup> <sub>p</sub> MIN		
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>3-7-1901</b>		6. AGE (n years lost birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON SAND HOSP.</b>				12a. USIA. OCCUPATION (Kind of work done during last 12 months (If ever retired)) <b>Electrician</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>		
13a. USIA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>TAKOMA PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>657-Houston Ave.</b>			
14 FATHER'S NAME First <b>M.</b> Middle <b>HENRY</b> Last <b>Kinsinger</b>				15. MOTHER'S MAIDEN NAME First <b>Florence</b> Middle <b>--</b> Last <b>Devlin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>--</b>				16b. SOCIAL SECURITY NO. <b>217-07-9213</b>		17 INFORMANT <b>Lois M. Kinsinger</b>				Address <b>Jak. Pk. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <b>Massive Right Ventricular Embolism 5 minutes</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>Pulmonary Embolism</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<b>Post Resection + graft Replacement of Ruptured Abdominal Aortic Aneurysm</b>											
19a. DATE OF OPERATION <b>11/26/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rupture Aortic Aneurysm</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>68</b> , to <b>12/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>11/25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Marvin L. Kolkin M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/4/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>MARVIN L. KOLKIN</b>						22e. ADDRESS <b>1015 Spring Street, S.S., Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-7-1'968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pr. Georges, Md.</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>						ADDRESS <b>Sil. Spr. Md.</b>		25a. REC'D BY REG. STRAR <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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VR A 5 (4)  
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>GEORGE</b> First Middle Last <b>NMI KIRK</b>					2a. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>1968</b>		2b. HOUR <b>9:31A</b>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>October 2, 1920</b>		6 AGE (In years and birthday) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>18</b> HOURS <b>18</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life or ever) <b>Foreign Service</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Dep</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8511 Rosewood Drive</b>	
14 FATHER'S NAME First Middle Last <b>George --- Kirichenko</b>					15 MOTHER'S MAIDEN NAME First Middle Last <b>Not Available</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes W.W.II</b>		16b. SOCIAL SECURITY NO <b>055-14-7668</b>		17 INFORMANT Address <b>Martha Kirk, Wife, Same as #13</b>						
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CORONARY ARTERY ATHEROSCLEROSIS FEW YRS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>440</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/18/68</b> to <b>12/24/68</b> , that (I) (we) last saw the deceased alive on <b>12/18/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>G. Lennard Gold</b> DECEASEE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/25/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>G. Lennard Gold</b>					22e. ADDRESS <b>9801 Georgia Ave, Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<b>Burial Transit</b>		<b>12/28/68</b>		<b>Maple Grove Cemetery</b>		<b>Queens, Long Island, N.Y.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Joseph Gawler's Sons, 5130 Wis. Ave, Wash., D.C.</b>					25a. REC'D BY REG. STRAR <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
45M - 1-69

17846									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Manner			Eita Kissinger			Dec 22 68			22 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Female		White		4/26/1896		72 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Suburban			CLAY C.H.			Pharmacist
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md			Mont			Chevy Chase			4623 Norwood Dr.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John J. Riegel			Mary Jane						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates or service)			16b. SOCIAL SECURITY NO			17. INFORMANT			
No			578-14-1273			Martin J. Kissinger			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u>									1 day
5990 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>6092</u>									
(b) <u>UTI - urinary tract infection</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>CVA, ASHD Cardio-vascular accident Heart Valve</u>									
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 12-10-1968 to 12-22-1968, that (I) (we) last saw the deceased alive on 12-22-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		22e. DATE SIGNED	
John S. Saia			JOHN S. SAIA			809 viers mill Rd, S.S., Md.		22 Dec 68	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			12-26-1968		St. Peters Church Cemetery Loyalton		Dauphin Pa.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc. 8434 Georgia Avenue			DEC 26 1968			Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
DORA			KLINE			ESTIMATED MONTH DAY YEAR		7:20 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD		2d HOUR		
Female	White	Dec. 25, 1891	76 (RS)			MONTH DAY YEAR		7:20 AM		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Poland		USA				Montgomery				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR (INDUSTRY)		
Silver Spring			Holy Cross Hospital			housewife				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery		Sil Sprg.		YES <input type="checkbox"/> NO <input type="checkbox"/>		815 Wesley Ave. SSMd.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Nathan			Kline			?				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
none					son in law Milton Charnow		11215 Oak Leaf Dr. SSMd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Extreme Injuries</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>(Internal) with Exsanguination</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 18 or Item 18)					
			7:20 AM 12-23-68		Deceased, a pedestrian, was struck by auto in street.					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State						
		Street		Hq. Ave. & Cameron St. Silver Spring, Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEC. 23, 1968				
BELOEN R. REAP, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
			ADDRESS (City or town or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		DEC. 24, 1968		Cedar Park Cemetery		Paramus, New Jersey				
24 FUNERAL DIRECTOR			ADDRESS			REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Donald M. Stein			232 Carroll St., N.W. Wash., D.C.			DEC 27 1968		p Charles Judge		
Hebrew Memorial Funeral Home										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ERNEST F KNIGHTING						Month 12 Day 24 Year 68		10 25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
M		W		4-1-88		80 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
VA.		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hosp.		Retired- Standard Brands					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, N.Y. YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Mont.		S.S.		YES <input type="checkbox"/> NO <input type="checkbox"/>		8403 Hartford Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First
John						Betty			Suthern
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
No			578-05-0813A			Margaret A. Knighting			Wife Same as #13
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									
PART 1. CAUSE WAS CAUSED BY IMMEDIATE CAUSE (a) acute Bronchopneumonia, bilateral									
485X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4. Positive ulcer - pulmonary emphysema									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19 P.M.							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 12-11-1968, to 12-24-1968, that (I) (we) last saw the deceased alive on 12-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D.L. Buecy						22c. DATE SIGNED		12-25-68	
22d. PHYSICIAN'S NAME (Type) D.L. Buecy						22e. ADDRESS		809 Veirs Mill Rd. Rockville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-28-68		Gate of Heaven		Silver Spring, Maryland.			
24. FUNERAL DIRECTOR Francis Hallis 500 University Blvd W Silver Spring, Md						25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> <span>17848</span> <span>CERTIFICATE OF DEATH</span> <span>17849</span> </div>										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
INFANT					Koehler				Month 12 Day 23 Year 68 2b. HOUR 30 M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
male		Caucasian		12-23-68					3.5	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Md.							Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY UNITS?		13e. STREET AND NUMBER	
Md.			P.G.		Hyatts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5112 41st Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
RONALD GARY KOEHLER			GLENDA LOU BOWMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
						mother				
18. CAUSE OF DEATH (Enter only one cause per line, to (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>7691</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>premature rupture of membr.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY; OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> , 19 <u>68</u> to <u>Jan 19</u> , that (I) (we) last saw the deceased alive on <u>12/23/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
C.R. Gilbert										30 Dec 68
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
C.R. Gilbert						344 Univ. Blvd W. Spring				
23a. BURIAL CREMATION, (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		12/30/68		Gate of Heaven Cemetery			Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler F.D., 1331 Rockville Pike, Rockville, Md. 20851						DATE JAN 3 1969		Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certificates, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
							Koehler "B"		Month 12 Day 23 Year 68 12 <sup>30</sup> PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR		
male		white		12-23-68			— YRS		MONTHS DAYS HOURS MIN 32		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
M.D.						Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holy Cross								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			P.G.		Hyatts		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5112 41st Ave		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Ronald			Garry Koehler		Glenda		Lou		Bowman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
						Mother					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Prematurity											
DUE TO, OR AS A CONSEQUENCE OF (b) Premature rupture of membrane											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1968, to 12/23, 1968, that (I) (we) last saw the deceased alive on Jan 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C.R.A. Gilbert						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/30/68			
22d. PHYSICIAN'S NAME (Type) C.R.A. Gilbert						22e. ADDRESS 344 Univ Blvd W. Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial			12/30/68		Gate of Heaven Cemetery		Silver Spring Montg.			Md.	
24. FUNERAL DIRECTOR Tyson Wheeler F. H. 1331 Rockville Pike						ADDRESS		25a. REC'D BY REGISTRAR			
Rockville, Maryland								DATE JAN 3 1969			
								25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <b>Mr. Gerald Morris Koenig</b>					2a. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>5:45 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>White-Caucasian</b>		5. DATE OF BIRTH <b>2/24/1911</b>		6. AGE (In years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanatorium Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Printer - G.P.O.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER <b>7307 Ocala St.</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>--</b> Last <b>Koenig</b>			15. MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b>--</b> Last <b>Muchek</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <b>No</b> (If yes give war or dates of service) <b>--</b>		16b. SOCIAL SECURITY NO. <b>122-88-5040</b>		17. INFORMANT <b>Laura S. Koenig</b>		Address <b>9307 Ocala St., Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gram neg. Bacteremia Shock</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Associated Condition Bacteremic Ca.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mo.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1621</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-20</b> , 19 <b>68</b> , to <b>12-13</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Lewis Dennis MD</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>DEC 13, '68</b>			
22d. PHYSICIAN'S NAME (Type) <b>LEWIS DENNIS MD</b>		22e. ADDRESS <b>2906 BEL PRO RD, SILVER SPRING</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-17-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hills Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Philadelphia, Pennsylvania</b>			
24. FUNERAL DIRECTOR <b>P.W. Lee Jr.</b>		ADDRESS <b>Sil. Spr., Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey</b>			
Warner E. Pumphrey, Inc. 8434 Georgia Avenue									



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

17841

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17852

1. DECEASED-NAME (Type or Print) <i>John Charles Kohlenberg</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 12-12 1968			2b. HOUR 9:35 M	
3 SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>1924</i>	6. AGE (in years last birthday) <i>44 YRS</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>Dec.</i> Day <i>12</i> Year <i>1968</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Labourer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bojds</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>John</i> Middle <i>Thomas</i> Last <i>Kohlenberg</i>		15. MOTHER'S MAIDEN NAME First <i>Georgia</i> Middle <i>Turner</i> Last <i>Turner</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, not known) <i>no</i>		16b. SOCIAL SECURITY NO <i>217-28-7990</i>	
17. INFORMANT <i>J. P. Kohlenberg</i>		ADDRESS <i>14 Montgomery</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Smoke inhalation and burns, second degree</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>116</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>9:35 PM 12 12 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>trapped in house fire</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No <i>18529 Strawberry Hill</i> City or Town <i>Bojds</i> County <i>Mont.</i> State <i>Md.</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John S. Ball</i>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Dec 13, 1968</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-16-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		23d. LOCATION (City or Town) (County) (State) <i>Ballsville, Mont. Md.</i>	
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>		ADDRESS <i>Gaithersburg, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

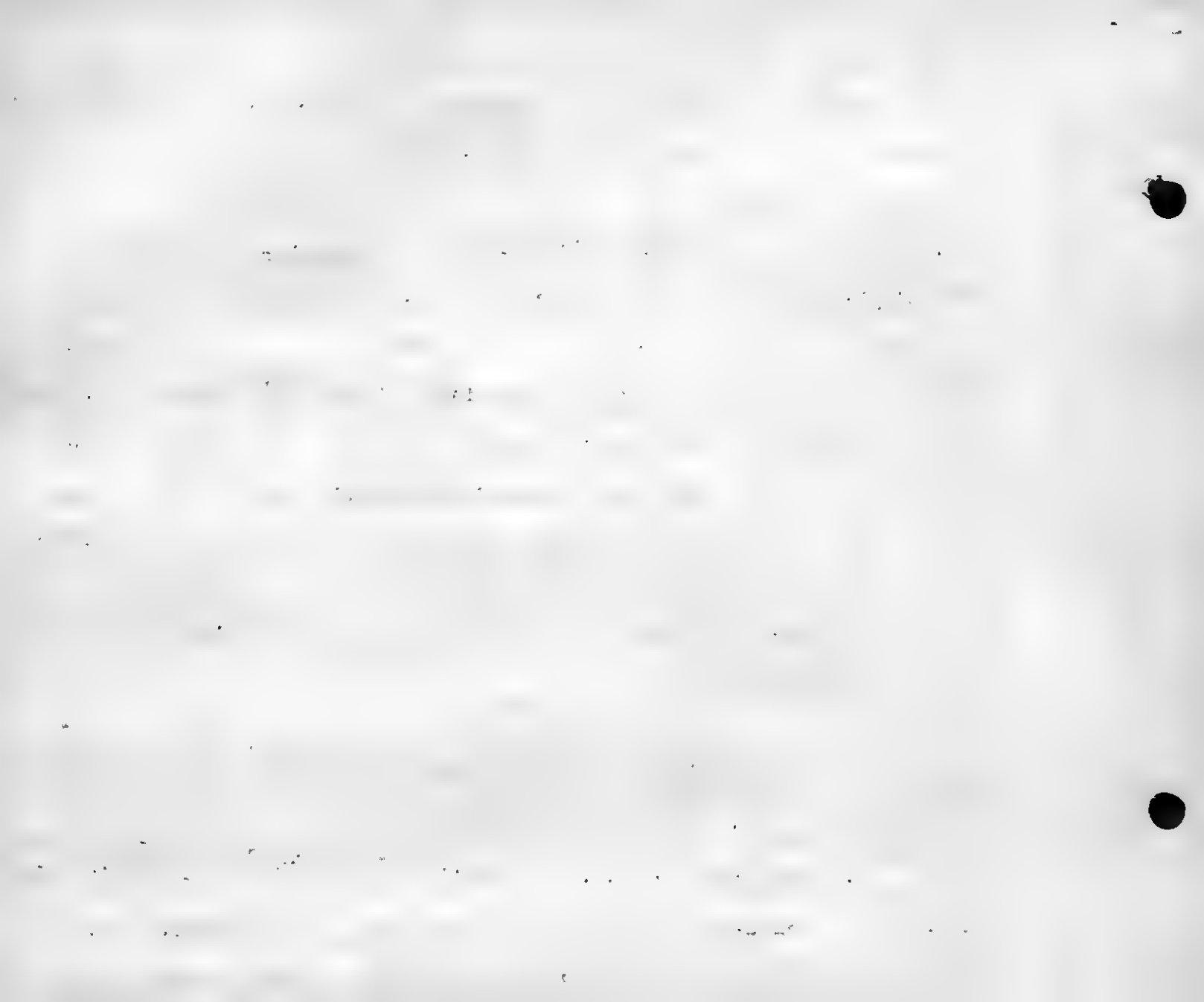


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First Middle Last <b>Eva Stella Kowalsky</b>			2a. DATE OF DEATH Month Day Year <b>December 4 1968</b>		2b. HOUR <b>7:15 A</b>
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>16 July 1905</b>	
7a. BIRTHPLACE (State or foreign country) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center</b>		12c. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>West Virginia</b>		13b. COUNTY <b>Raleigh</b>		13c. CITY OR TOWN <b>Raleigh</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 234</b>			
14. FATHER'S NAME First Middle Last <b>John Idgocki</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Haratyk</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>233-30-9912</b>		17. INFORMANT Address <b>The Medical Records The Clinical Center, NIH, Bethesda, Md. 20014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <b>Gram negative sepsis</b>					<b>12 hours</b>
DUE TO, OR AS A CONSEQUENCE OF <b>infarction</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					<b>weeks</b>
DUE TO, OR AS A CONSEQUENCE OF <b>Intestinal obstruction - probably bowel /</b>					
DUE TO, OR AS A CONSEQUENCE OF <b>Recurrent cancer of uterus</b>					<b>months</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<b>124x</b>					
19a. DATE OF OPERATION <b>7/18/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of uterus</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>23 Nov.</b> , 19 <b>68</b> , to <b>4 Dec.</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>4 December</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.					
22b. SIGNATURE <b>H. Bryan Neel, III, M.D.</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4 December 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>H. Bryan Neel, III, M.D.</b>		22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-7-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Beckley West Virginia</b>					
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>7657 isconsin Bethesda, Md</b>		25b. REGISTRAR'S SIGNATURE <b>DEC 9 1968</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M 1/69

17813		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		17854	
1 DECEASED-NAME (Type or print) <i>Lester</i>		First Middle Last		2a DATE OF DEATH		2b HOUR	
3 SEX <i>Male</i>		4 RACE <i>W. White</i>		5 DATE OF BIRTH <i>4/23/1917</i>		6 AGE (In years last birthday) <i>51</i>	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USAL OCCUPATION (Kind of work done during most of work week, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>Peter Kryger</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Ida Van Kuld</i>		13e. STREET AND NUMBER <i>11208 Lombardy Rd.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes Navy</i>		16b. SOCIAL SECURITY NO. <i>143-09-8722</i>		17 INFORMANT <i>Wife Henrietta Kryger</i>		Address <i>Same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent &amp; remote</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe coronary arteriosclerosis with occlusion</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
<i>4109</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <i>12/17/68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/19/67</i> , 19 <i>67</i> , to <i>12/17/68</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>12/12/68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. W. Shapiro</i>				22c. DATE SIGNED <i>12/17/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>M. W. SHAPIRO</i>				22e. ADDRESS <i>8107 EASTERN AVE, SILVER SPRING, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12-19-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LAUREL GROVE</i>		23d. LOCATION (City or Town) (County) (State) <i>TOTOWA, N. J.</i>	
24. FUNERAL DIRECTOR <i>COLLINS FUNERAL HOME</i>				25a. REC'D BY REGISTRAR <i>DEC 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
500 UNIVERSITY BLVD. W. SILVER SPRING, MD.							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 2 and 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>17814</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>17855</p> </div> </div> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>- years -</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8484 16th Street; Apt #908</b>				d. STREET ADDRESS <b>8484 16th Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (type or print) <b>ELLA</b> First Middle Last				4. DATE OF DEATH <b>DECEMBER 22 1968</b> Month Day Year							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 15, 1888</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zalman Murnik</b>				14. MOTHER'S MAIDEN NAME <b>Chaya</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Jeanette Goldman</b> Address <b>2212 Ross Road Silver Spring, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> 4-1-7 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>332</b> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE; DIABETES MELLITUS</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 28, 1960</b> , to <b>DECEMBER 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec-21 1968</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Israel Kessler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>12/22/68</b>			
22c. PHYSICIAN'S NAME (Type) <b>ISRAEL KESSLER, M.D.</b>				22d. ADDRESS <b>5801-16 St. NW, WASH, D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>				23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>			
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b> ADDRESS <b>3501-14th St. N.W. Wash, D.C. 20010</b>				25a. REC'D BY REGISTRAR <b>DEC 30 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

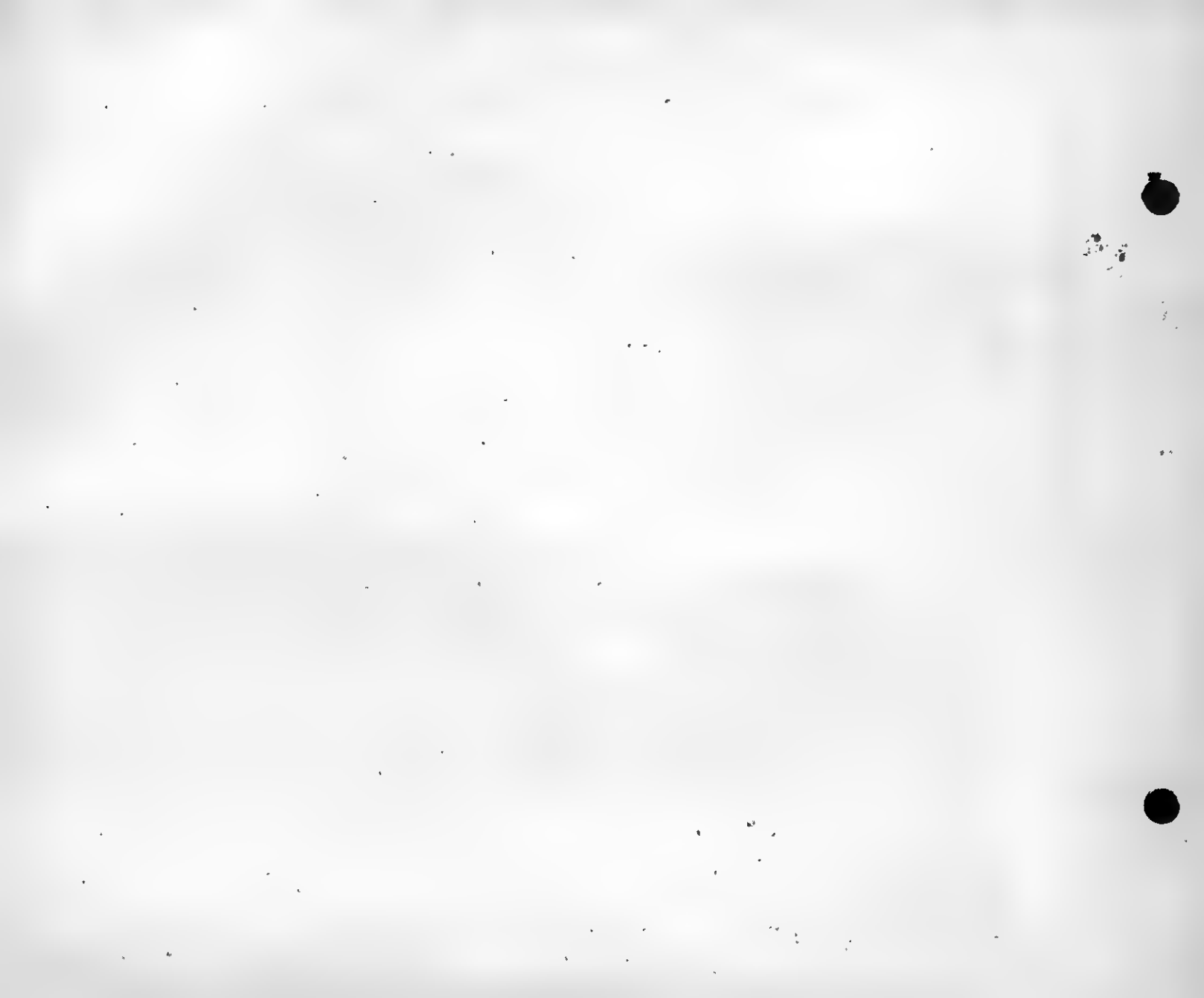


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115  
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M			
DeSales				K.	Lacey	Dec. 23 1968					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		White		11-14-14		54 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.					
Penn.		USA				Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Wash. Hospital & San			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3300 Medway St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John					Carey	Bridget					Clark
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No						DeSales Ann Lacey			Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1) cardiovascular disease 2) malnutrition</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4</u> <u>3 days</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1/68</u> , 19 <u>68</u> , to <u>12/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/23/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Patrick C. Jameson</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/24/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson</u>						22e. ADDRESS <u>117186 or j-a Sil. Spring Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		12/27/68		Gate of Heaven		Silver Spring, Mont				Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Collins Funeral Home				500 University Blvd. W. Silver Spring, Md.		DATE <u>DEC 30 1968</u>		<u>J. Charles Judge</u>			



17816

## CERTIFICATE OF DEATH

17857

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 DECEASED NAME (Type or print)		First Elizabeth	Middle NMN	Last Ladson	2a DATE OF DEATH Dec. Month 17 Day 68 <sup>or</sup>		2b HOUR 2:55 <sup>PM</sup>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11-20-18		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3007 Olney-Sandy Spring Rd.
14. FATHER'S NAME Alexander		First Middle Last Alexander McGill		15. MOTHER'S MAIDEN NAME First Middle Last Lois Nicholson				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na. or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO Unknown		17 INFORMANT Hospital Records		Address Olney, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> 5719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bleeding Esophagus Varices</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Liver</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 days 6 mos								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5210 <u>Cerebral</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (the <del>physician</del> ) attended the deceased from <u>12/16</u> , 19 <u>68</u> , to <u>12/17</u> , 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/16</u> , 19 <u>68</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>do not</del> ) view the body after death.								
22b. SIGNATURE <u>Dr. Charles Ligon</u>		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/17/68		
22d. PHYSICIAN'S NAME (Type) Dr. Charles Ligon		22e. ADDRESS Sandy Spring Md 20860						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-20-68		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md.		
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE <u>DEC 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





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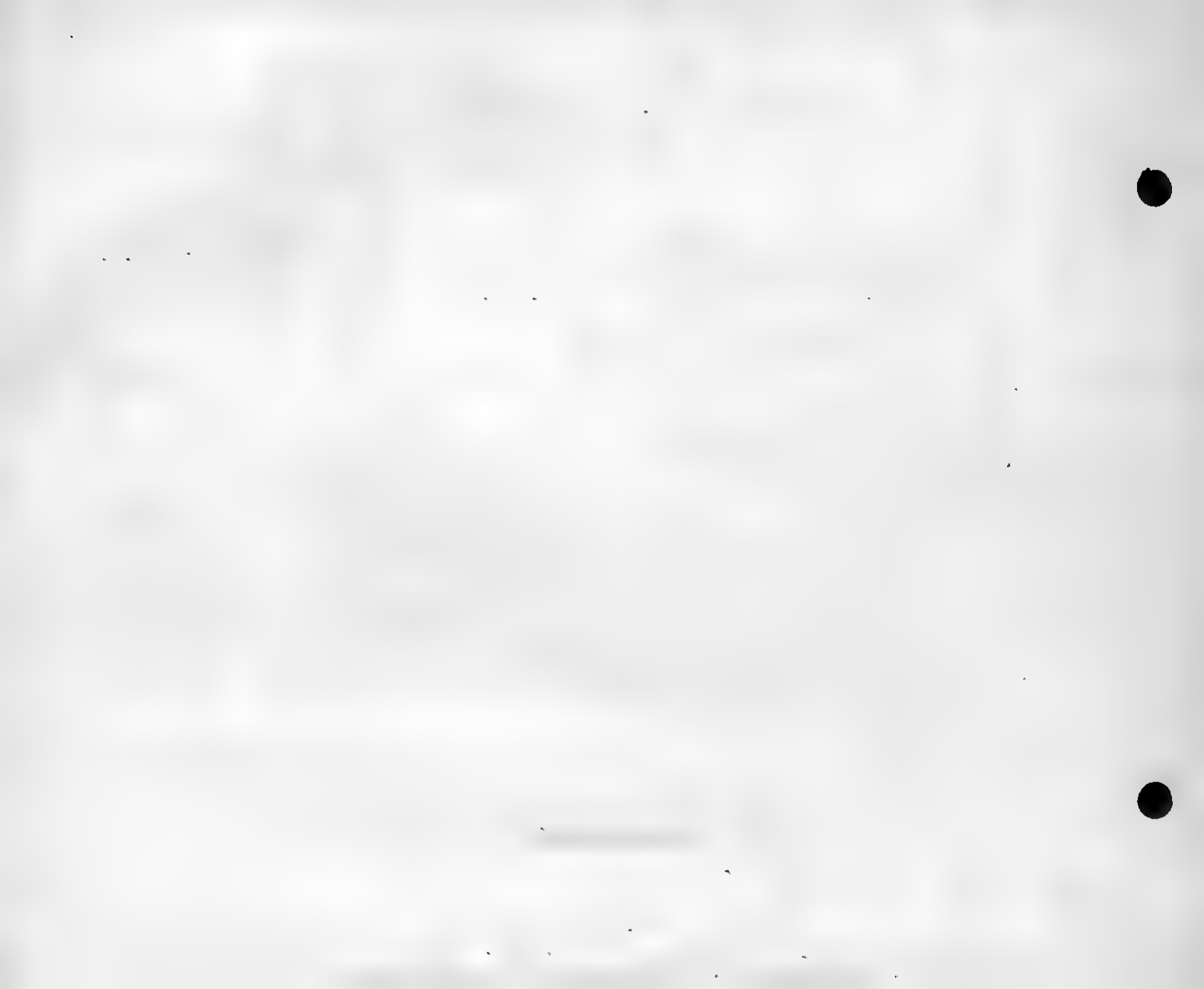
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>DONATA</b>			First <b>E.</b> Middle <b>E.</b> Last <b>LANAHAN</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>68</b>		2b. HOUR <b>9:30</b> AM		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-25-89</b>		6. AGE (In years last birthday) <b>79</b> YRS		7. UNDER 1 YEAR MONTHS <b>12</b> DAYS <b>26</b>		
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Mary Cross</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Govt., U.S.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>11411 Viers Mill Rd.</b>	
14. FATHER'S NAME First <b>Thomas</b> Middle <b>--</b> Last <b>Ortman</b>			15. MOTHER'S MAIDEN NAME First <b>(Unknown)</b> Middle <b>--</b> Last <b>--</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b> (If yes give war or dates of service) <b>--</b>				
16b. SOCIAL SECURITY NO <b>None</b>			17. INFORMANT Address <b>Wheaton, Md.</b> <b>Cornelius E. Lanahan 11411 Viers Mill Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PULMONARY EDEMA</b> <b>412</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident (Embolic)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio-Sclerotic Heart Disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 days</b> <b>5 yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>5 yrs.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>26</b> Year <b>1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>65</b> , to <b>12/26</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/25/68</b> , 19 <b>68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death										
22b. SIGNATURE <b>Francis X. Richardson</b>			22c. DATE SIGNED <b>12/26/68</b>			22d. PHYSICIAN'S NAME (Type) <b>FRANCIS X. RICHARDSON</b>				
22e. ADDRESS <b>11412 Viers Mill Road Silver Spring Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12-30-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Montgom. Md.</b>	
24. FUNERAL DIRECTOR <b>W. Lee</b>			ADDRESS <b>Sil. Spr., Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



## CERTIFICATE OF DEATH

Cleared by Medical Examiner Dr. Belden Reed

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First <u>Albert</u> Middle <u>E.</u> Last <u>LEEF</u>						2a. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>68</u>			2b. HOUR <u>12</u> MIN <u>48</u>		
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>6-9-1920</u>		6 AGE (In years last birthday) <u>48</u> YRS.		7 UNDER 1 YEAR MONTHS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.					
10 CITY OR TOWN OF DEATH <u>Bethesda</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>NAVAL Research</u>			12b KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b COUNTY <u>Montgomery</u>			13c CITY OR TOWN <u>Kensington</u>		13d INSIDE CITY LIM 1ST YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>4403 Edgetfield Rd.</u>	
14. FATHER'S NAME First <u>Henry</u> Middle <u>Albert</u> Last <u>Leef</u>				15 MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>TERRY</u> Last <u>Williams</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>yes</u>			16b. SOCIAL SECURITY NO (If yes give war or dates of service) <u>577-12-6335</u>			17. INFORMANT <u>Elvira Lois Leef</u> Address <u>SAME AS #13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u>										<u>1 hr</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u>										<u>5 years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>Dec 30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Observed with medical examiner</u>											
22b SIGNATURE <u>Robert N. Coale M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 30, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>						22e ADDRESS <u>4429 Bradley Lane, Chevy Chase Md.</u>					
23a B. RIAL CREMATION, REMOVAL (Specify)		23b DATE <u>1-4-1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory,</u>		23d LOCATION (City or Town) <u>Suitland,</u>		County <u>Prince Georges</u>		State <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N. WI, Wash., D.C., 20016</u>						25a. REC'D BY REGISTRAR <u>JAN 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

PR 10-1-68  
30M-10-1-68



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Sophie Charlotte Link</b>						2a. DATE OF DEATH Month <b>Dec</b> Day <b>4</b> Year <b>1968</b>		2b. HOUR <b>6:25 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>Cauc</b>		5. DATE OF BIRTH <b>Dec 10, 1880</b>		6 AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10 CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>University of Maryland</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>own home</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Montgomery, Md.</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Sil. Spr.</b>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>98 Eldrid Drive</b>			
14 FATHER'S NAME First <b>Henry</b> Middle <b>--</b> Last <b>Kreienberg</b>				15. MOTHER'S MAIDEN NAME First <b>Marie</b> Middle <b>--</b> Last <b>Henck</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>				16b SOCIAL SECURITY NO <b>135-09-7528D</b>		17. INFORMANT Address <b>Maryland Sil. Spr.</b>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Coronary occlusion, acute</b>											
DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerosis, coronary &amp; genit</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>hypertension</b>											
DUE TO, OR AS A CONSEQUENCE OF <b>hypertension</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1) <b>Anemia, auto-hemolytic</b> 2) <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June, 1950</b> , to <b>Dec. 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov. 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Philip H. Varner, M.D.</b>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-4-68</b>			
22d PHYSICIAN'S NAME (Type) <b>Philip H. Varner, M.D.</b>						22e ADDRESS <b>10620 Georgia Ave., Wheaton, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
<b>Cremation</b>		<b>12-7-1968</b>		<b>St. Lincoln Crematory</b>		<b>Prince Georges</b>		<b>Maryland</b>			
24 FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>						ADDRESS <b>Sil. Spr. Md.</b>		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
<b>8434 Georgia Avenue</b>						<b>DEC 12 1968</b>					

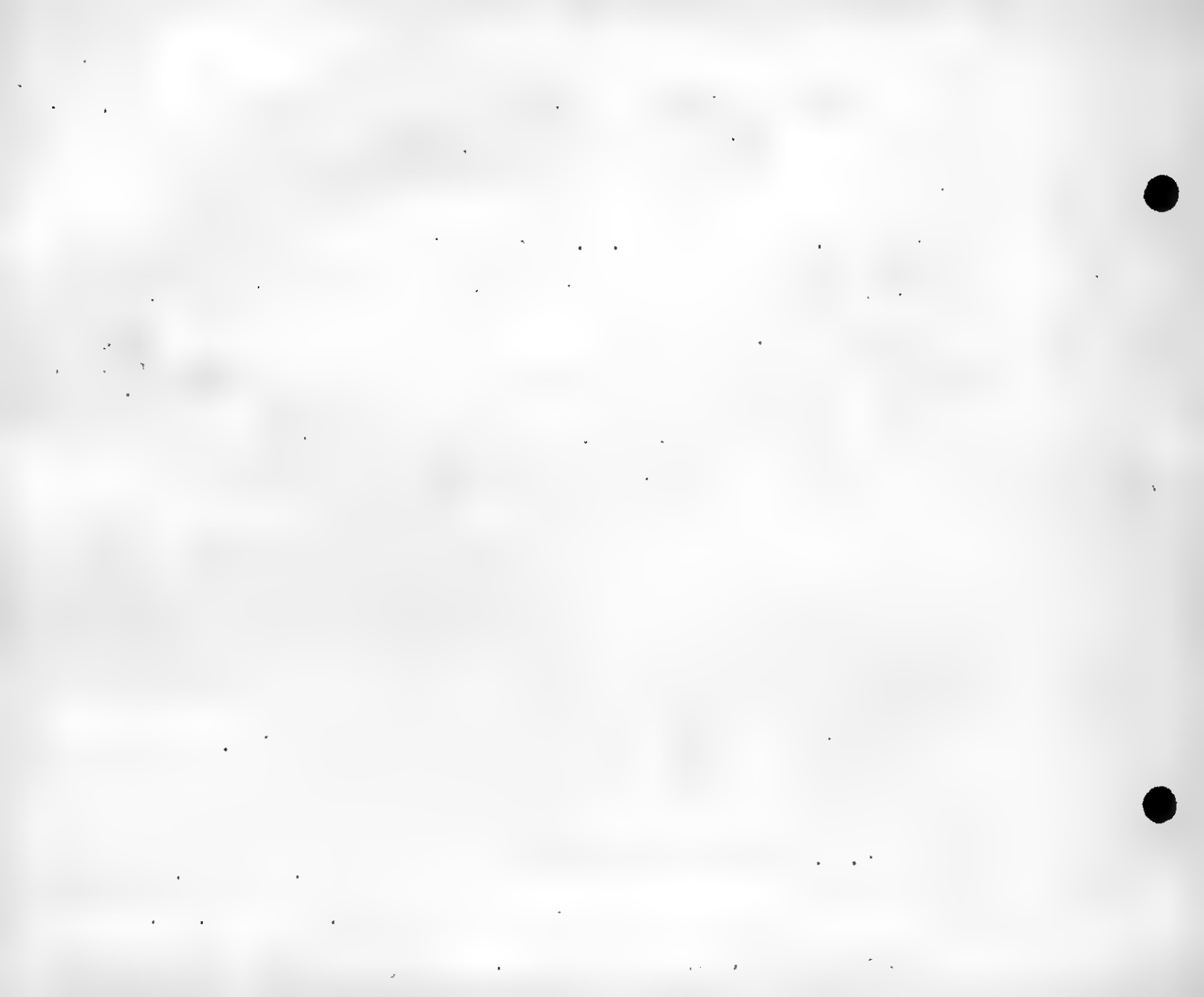




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>17851</div> <div>Item 6 Film 0407 12/23/68 kk</div> <div>CERTIFICATE OF DEATH</div> <div>17862</div>											
1. DECEASED NAME (Type or print) First Middle Last <b>ROBERT REYNOLDS LOGAN</b>						2a. DATE OF DEATH Month Day Year <b>December 14 1968</b>			2b. HOUR <b>12:10</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>26 JAN 1913</b>		6. AGE (In years last birthday) <b>55 YRS</b>		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County, Md</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>U. S. Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>USN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Lexington Park</b>		13c. CITY OR TOWN <b>Lexington Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>314 Midway Drive</b>			
14. FATHER'S NAME First Middle Last <b>Robert M. LOGAN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Leatha REEVES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>359 20 2912</b>		17. INFORMANT <b>Eva Ella LOGAN (Wife)</b>		17. ADDRESS <b>Lexington Park, Md. 314 Midway Dr.,</b>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA OF STOMACH</b> <b>1510</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Abdominal Abscesses with Diffuse</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adhesions and Peritonitis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1512</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>21 August, 1968</b> , to <b>14 Dec., 1968</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>14 Dec. 1968</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>(X)</del> (we) (did) <del>(not)</del> view the body after death.											
22b. SIGNATURE <i>K. R. Matheis</i> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>15 December 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>K. R. MATHEIS MD (LT MC USN)</b>						22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/18/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington, Va.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>					
24. FUNERAL DIRECTOR <i>Robinson Welch</i> ADDRESS <b>Robinson Funeral Home, Leonardtown, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 18 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## CERTIFICATE OF DEATH

17852

17863

1. DECEASED NAME (Type or print) <b>Ellen Hennings LYONS</b>			2a. DATE OF DEATH 8 December 1968			2b. HOUR 9:55A M			
3. SEX <b>Female</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH 15 Feb 1913		6. AGE (In years lost birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			Md
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USJA. OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>			
13a. USJA. RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>Bryans Rd.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 1, Box 167</b>	
14. FATHER'S NAME <b>Frederick HENNINGS</b>			15. MOTHER'S MAIDEN NAME <b>Virgie Anna BURGESS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-07-5044</b>		17. INFORMANT <b>Chester A. LYONS, Rt 1, Box 167, Bryans Rd, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra-abdominal hemorrhage</b> <b>4</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Rupture of false aneurysm of right common iliac artery</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>2 X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from <b>8 December, 1968</b> , to <b>8 December 1968</b> , that (X) (we) last saw the deceased alive on <b>8 December 1968</b> , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. A. Routenberg Lt/MC</b>				22c. DATE SIGNED <b>9 December 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>J. A. ROUTENBERG</b>		22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11 Dec 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hills Cemetary</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Pr. Georges, Md.</b>			
24. FUNERAL DIRECTOR <b>Huntt Funeral Home, Waldorf, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR HRS MIN	
Cecil W. Macey					Dec. 22 1968		4:00 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN
male	white	2/28/1944		74 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Iowa	U.S.A.			Montgomery				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work, not 16, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda	Suburban Patient Home		Patient		Ret.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY, M.T.S.P. YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Md.	Mont.	Bethesda			6721 Grosvenor Lane			
14 FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Cecil	W.	Macey		Lillian				Wang
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17. INFORMANT		Address				
Yes	U.S. Army	John Talbot		11425 1/2 1st St. N.W.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism								1/2 hours
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								2 days
(b) Emboli from thrombosis, right femoral vein.								
(c) Post-surgical resection carcinoma, colon								10 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
123								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Dec 11 68	Carcinoma Colon		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 8, 1968, to Dec 22, 1968, that (I) (we) last saw the deceased alive on Dec 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE		22c DATE SIGNED		22e ADDRESS				
Robert G. Brewer MD		12/22/68		8505 Old Georgetown Rd. N.W.				
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS		22f. REC'D BY REGISTRAR				
ROBERT G. BREWER				DATE DEC 27 1968				
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		23e REC'D BY REGISTRAR		
Buried	Dec 27, 1968	Rock Creek Cemetery		Washington D.C.		23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR		ADDRESS		25. REC'D BY REGISTRAR				
Arthur Walters		254 Carroll St NW Wash DC		DATE DEC 27 1968				



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17865
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Richard OSWALD Mai			2a. DATE OF DEATH Month Day Year December 28 1968			2b. HOUR 9:15 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-29-1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Coburn Villa Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Banker		12b. KIND OF BUSINESS OR INDUSTRY -				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Delaware		13b. COUNTY SUSSEX		13c. CITY OR TOWN Greenwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER MARKET		
14. FATHER'S NAME First Middle Last CHARLES FREDERICK MAI Dec			15. MOTHER'S MAIDEN NAME First Middle Last ANNA MARIE KOEHLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown Unknown		16b. SOCIAL SECURITY NO 221-09-4381A		17. INFORMANT R. EVERETT MAI		Address 570 HAWKERS BLVD LANE 3 Spring, Md 20904				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486X DUE TO, OR AS A CONSEQUENCE OF (b) <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 days</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Malnutrition, dehydration, chronic brain syndrome arterio/sclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> , 1967, to <u>12/28</u> , 1968, that (I) (we) lost saw the deceased alive on <u>12/13</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.H. Sandstrom MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/28/68				
22d. PHYSICIAN'S NAME (Type) R.H. Sandstrom MD		22e. ADDRESS 7701 Carroll Ave Jk & K Md								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-31-68		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNSTOWN			23d. LOCATION (City or Town) (County) (State) GROETON GREENWOOD SUSSEX DEL.			
24. FUNERAL DIRECTOR William Fleischer		ADDRESS Greenwood		25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17855		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17866	
Item #7b Film #G408 12/31/68 vmp							
1 DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR	
Sarah MARKMAN			Dec. 20 1968			1. A M	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	
Female		White		9/18/1882		86 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Russia		U.S.A.		Montgomery		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton		Randolph Hills Nursing Home		Nursing			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		MONTGOMERY		BETHESDA		13e. STREET AND NUMBER	
						5820 Durbin Road	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Aaron Chideckel			BAILA RASHA			Kashner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT		Address	
		216-01-6999-D		Mrs. Beverly Zitelman		5820 Durbin Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Yrs.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8/20/67, to 12/20/67, that (I) (we) lost the deceased on 12/14/67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. T. BENACK MD				22c. DATE SIGNED 12/20/68			
22d. PHYSICIAN'S NAME (Type) R. T. BENACK MD				22e. ADDRESS 4115 Colie DR. Wheaton, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		DEC. 22, 1968		Hebrew Young Men's Cemetery		Baltimore, Maryland	
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Donald M. Stein		232 Carroll		DEC 24 1968		J. Charles Judge	
Hebrew Memorial Funeral Home St. N.W. Wash., D.C.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54  
30M REV 1-54

17856

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17867

# CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Richard N Martin</i>			2a DATE OF DEATH Month <i>Dec</i> Day <i>23</i> Year <i>1968</i>			2b HOUR <i>4:45</i> M	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>8/13/93</i>		6 AGE (In years last birthday) <i>75</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>West. Va.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U S</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Montgomery</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RES DENCE (Where deceased lived, if institution Res dence before admission) STATE <i>md</i>		13b COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <i>7005 Old State Road</i>							
14 FATHER'S NAME First Middle Last <i>Richard Martin</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Annice Williams</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give War or dates of service) <i>None</i>			16b SOCIAL SECURITY NO.		17 INFORMANT <i>Richard Martin</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC CARCINOMA</i> <i>185X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA OF PROSTATE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>4 years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>MYOCARDIAL INFARCTION 1964</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <i>DEC 29, 1962</i> , to <i>DEC 23, 1968</i> , that (I) (we) last saw the deceased alive on <i>DEC 23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael S. Madeloff</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED D DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>12/23/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>MICHAEL S. MADELOFF</i>				22e ADDRESS <i>10620 Georgia Ave. Silver Spring, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12-26-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a REC'D BY REGISTRAR <i>JAN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17868

1 DECEASED-NAME (Type or print) <u>Rosemary Catherine Marvel</u>			2a DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1968</u>			2b HOUR <u>6:50</u> P.M.	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>4/2/25</u>		6. AGE (In years lost birthday) <u>43</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		7b CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery County</u> Md.	
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanatorium Hospital</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>		13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Wheaton</u>		13d. HSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <u>Michael J. McKnight</u>		15 MOTHER'S MAIDEN NAME First Middle Last <u>Rosemary ? Doemling</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>			
16b. SOCIAL SECURITY NO. <u>219-12-488</u>		17. INFORMANT <u>Rosemary E. Marvel, Jr.</u>		Address <u>2814 Hardy Ave.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma. Pneumonia</u> 5710 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>alcoholism</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Upper GI Bleeding</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>68</u> , to <u>Dec 20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. Russell Bufalino MD</u>		DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 21, 68</u>	
22d. PHYSICIAN'S NAME (Type) <u>RUSSELL BUFALINO MD</u>		22e. ADDRESS <u>1429 University Blvd W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-24-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

17869

1. DECEASED NAME (Type or print) <b>Edgar</b>		First <b>Edgar</b>		Middle <b>Paul</b>		Last <b>Mason</b>		2a. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1968</u>		2b. HOUR <u>12</u> PM	
3. SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>3/06/05</b>		6 AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS HOURS <u>  </u> MIN <u>  </u>	
7a BIRTHPLACE (State or foreign country) <b>Mt Vernon Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md					
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>sign painter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>NONE</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>SSMd.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>1516 Jasper St. SSMd.</b>			
14. FATHER'S NAME First <b>Noel</b>		Middle <b>--</b>		Last <b>Mason</b>		15 MOTHER'S MAIDEN NAME First <b>Mary</b>		Middle <b>--</b>		Last <b>Shade</b> <del>Shade</del>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		(If yes give war or dates of service) <b>--</b>		16b SOCIAL SECURITY NO <b>578-24-8493</b>		17 INFORMANT <b>Eulah C. Mason</b>		Address <b>1516 Jasper St. SSMd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction (Heart attack) 5 min</b> <b>4104</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic coronary artery disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Myocardial infarction old 1957-1959-1962</b>											
19a. DATE OF OPERATION <b>11/22/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>chronic thrombosis</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF N.Y.R. HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>19</b>		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 1, 1949</b> , to <b>Dec 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>George L. Dall</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Dec 24, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>George L. Dall</b>		22e. ADDRESS <b>1516 Jasper St. SSMd.</b>									
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-28-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Montgomery Md.</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>Jan 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 30 days after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR			
Elwine		J.		Matre	12-29-68			10:40 PM			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		
Female	white		6-19-96		72 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Ohio		U.S.A.				Montgomery Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Montgomery		Silver Sp.				1907 Rookwood Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give branch or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			
Gustavus		Junkerman		Pearl		Not Known		Mrs Robert Long Cincinnati Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH CAUSED BY:											
IMMEDIATE CAUSE (a) acute myocardial infarction											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21f. LOCATION Street or R.F.D. No City or Town County State	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
22a. I certify that (I) (this hospital) attended the deceased from 12/13, 1968, to 12/29, 1968, that (I) (we) last saw the deceased alive on 12/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Sidney J. Malawer										22c. DATE SIGNED 12/29/68	
22d. PHYSICIAN'S NAME (Type) SIDNEY J. MALAWER, M.D.										22e. ADDRESS 8218 Wisconsin Avenue, Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/02/69		Spring Grove Cemetery Cincinnati Ohio							
24. FUNERAL DIRECTOR		25a. REGISTERED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE					
ROBERT A. PUMPHREY, Bethesda, Maryland		7557 Wisconsin Ave. JAN 6 1969		J. P. Jones							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17860											
17871											
1 DECEASED-NAME (Type or print) First Middle Last <b>FRANCES GERALDINE MATTERS</b>						2a DATE OF DEATH Month Day Year <b>DECEMBER 18 1968</b>			2b HOUR <b>2:40 PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>SEPT 18, 1899</b>		6. AGE (In years last birthday) <b>69 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign) <b>MASSACHUSETTS</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>MONTGOMERY</b> Md					
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>NAVAL HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>MARYLAND</b>		13c CITY OR TOWN <b>PRINCE GEORGE'S HYATTSVILLE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>3450 TOLEDO TERR</b>					
14 FATHER'S NAME First Middle Last <b>WILLIAM F. RUANE</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>NELLIE CONNOLLY</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b SOCIAL SECURITY NO. <b>579-48-4266</b>		17 INFORMANT <b>HUSBAND HAROLD P. MATTERS</b>		3450 TOLEDO TERR <b>HYATTSVILLE, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pending further study of central nervous system</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Asthmatic bronchitis-clinical</u>										years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>500</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from <b>DEC 17</b> , 19 <b>68</b> , to <b>DEC 18</b> , 19 <b>68</b> , that <b>XX</b> (we) last saw the deceased alive on <b>DEC 18</b> , 19 <b>68</b> , and that in <b>(XX)</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(X)</b> (we) (did) <b>(XXXX)</b> view the body after death.											
22b SIGNATURE <u>M. Schenk</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <b>20 DECEMBER 1968</b>					
22d PHYSICIAN'S NAME (Type) <b>T. M. SCHENK, M.D.</b>				22e ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MARYLAND</b>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
<b>BURIAL</b>		<b>Dec 23, 1968</b>		<b>ARLINGTON NATIONAL CEMETERY</b>		<b>ARLINGTON VIRGINIA</b>					
24 FUNERAL DIRECTOR <b>GASCH'S SONS</b>				4739 BALTIMORE AVE		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<b>FUNERAL HOME</b>				<b>HYATTSVILLE, MD.</b>		<b>DEC 24 1968</b>		<u>Charles Judge</u>			

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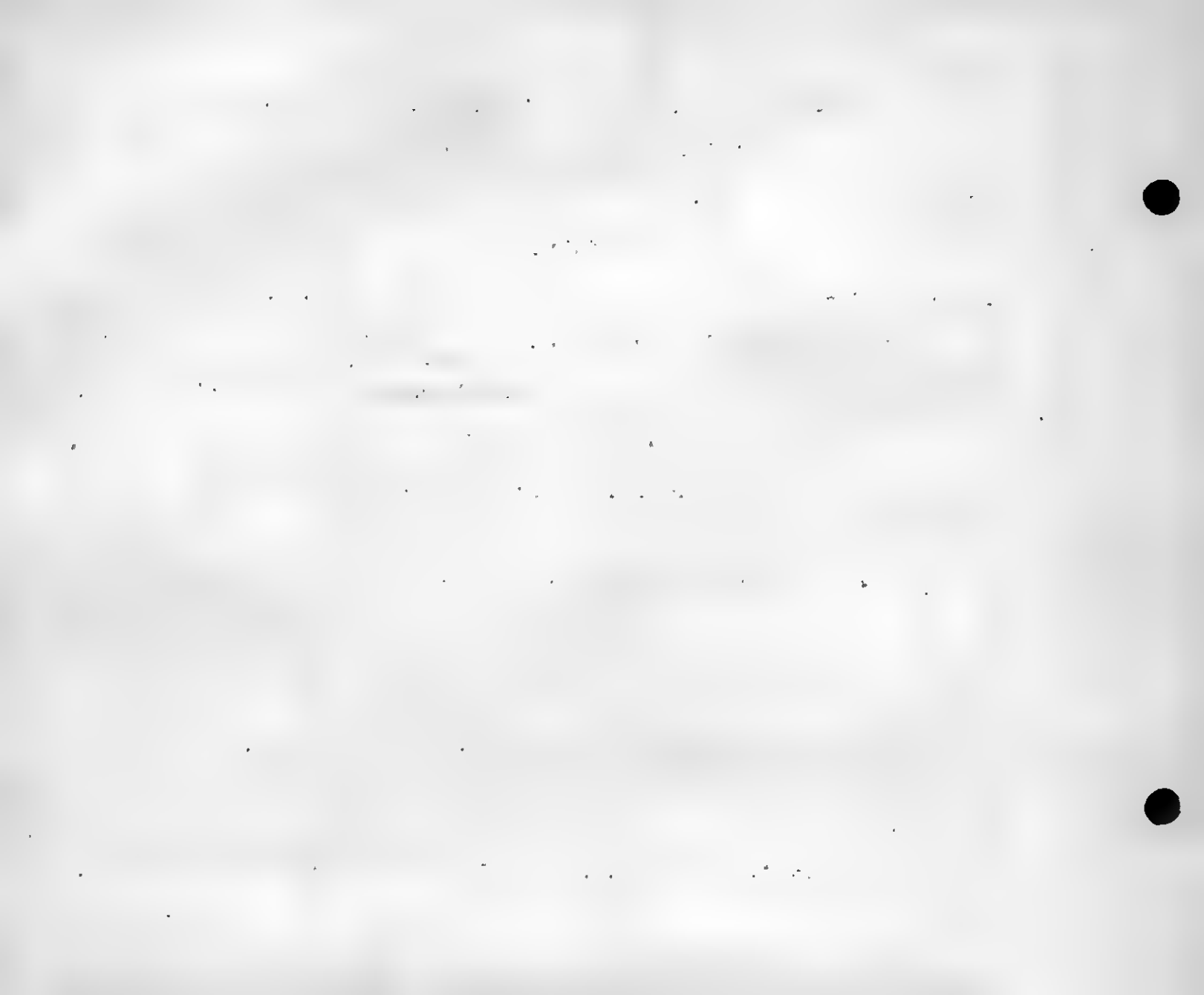
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VR A15 (4)  
DOM REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																					
CERTIFICATE OF DEATH										17872											
1 DECEASED NAME (Type or print)				First <b>James</b>				Middle <b>Howard</b>				Last <b>Mattox, Jr.</b>				2c DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1968</b>				2b HOUR <b>3:45</b> M	
3 SEX <b>Male</b>				4 RACE <b>White</b>				5 DATE OF BIRTH <b>8 March 1959</b>				6 AGE (In years last birthday) <b>9</b> YRS.				7c UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7d UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>			
7a BIRTHPLACE (State or foreign country) <b>South Carolina</b>				7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Montgomery</b>				Md					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>The Clinical Center</b>				12a USUAL OCCUPATION (Kind of work done during most of two years, even if retired) <b>Student</b>				12b KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>South Carolina</b>				13b COUNTY <b>Ridgeway</b>				13c CITY OR TOWN <b>Ridgeway</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER <b>P. O. Box 181</b>					
14. FATHER'S NAME First <b>James</b>				Middle <b>Howard</b>				Last <b>Mattox, Sr.</b>				15. MOTHER'S MAIDEN NAME First <b>Virginia</b>				Middle <b>Miles</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>None</b>				17 INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, NIH, Bethesda, Md. 20014</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas septicemia</b> DUE TO, OR AS A CONSEQUENCE OF <b>neutropenia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>287.2</b> (b) <b>Dysgammaglobulinemia, chronic hypoplastic/</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>hours</b> <b>years</b>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Extensive necrotizing pseudomonal ulcerating lesion right forearm</b>																					
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town County State									
22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>2 Dec.</b> , 19 <b>68</b> , to <b>5 Dec.</b> , 19 <b>68</b> , that <del>xx</del> (we) last saw the deceased alive on <b>2 December</b> 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>xx</del> (we) (did) <del>not</del> view the body after death.																					
22b. SIGNATURE <b>Richard A. Johnson</b> - DEGREE												ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5 December 1968</b>							
22d. PHYSICIAN'S NAME (Type) <b>Richard A. Johnson, M.D.</b>								22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE <b>12.7.68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ainwell Cemetery</b>				23d LOCATION (City or Town) (County) (State) <b>Ridgeway S. Carolina</b>									
24. FUNERAL DIRECTOR <b>Lee Funeral Home. 300.4th st N E D C.</b>								ADDRESS <b>Wash</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
ANDRE F				Mawhinney				Month Day Year 12 23 68		5A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		NOV 19, 1877		69 YRS		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New Jersey		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Rockville, Md		Potomac Valley Hosp Home		Retired Gov't Employee							
13a USUA. RES DENCE (Where deceased lived, if institution admission)		13b COUNTY		13c CITY OR TOWN		13d STATE CITY, TOWNSHIP		13e STREET AND NUMBER			
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4905 Ertter Drive			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Unknown								Mary		Forsyth	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT							
No		None		Robert F. Mawhinney, Jr.		4048 Collwood La. San Deigo, Cal					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Parkinson's Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm street factory) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1968, to Dec 23, 1968, that (I) (we) last saw the deceased alive on Dec 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c. DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
Dr Joseph P. Kenrick MD		12/23/68		DR JOSEPH P. KENRICK		6450 Wisconsin Ave, Bethesda, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		12/26/68		Arlington Nat'l Cem.		Arlington, Virginia					
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY,		7557 Wisconsin Ave, Bethesda, Maryland		JAN 2 1969		Charles Judge					



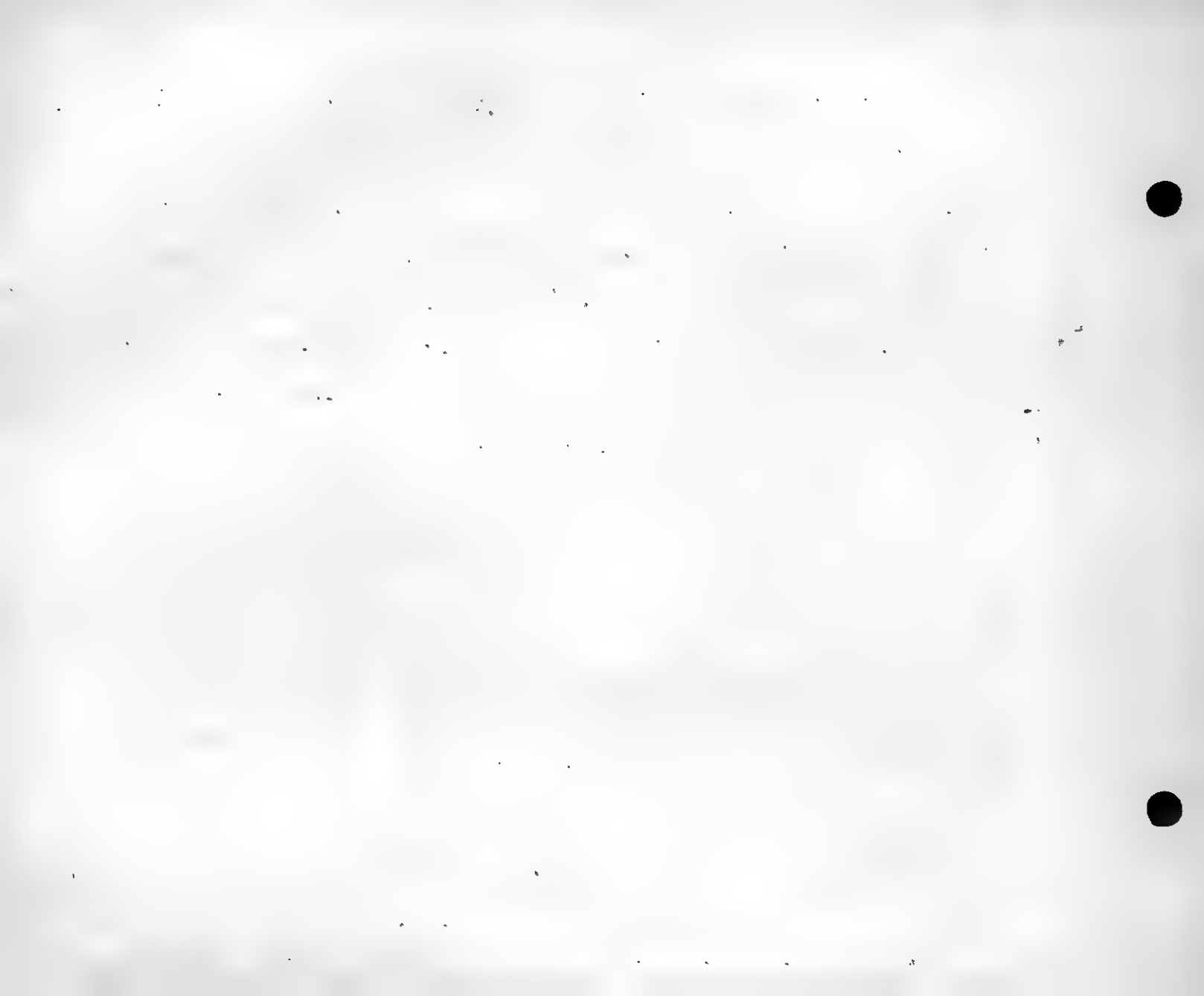


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VR A15  
304 REV 7/68

17874											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JEANETTE		E		MAX				12 Month 26 Day 1968		10:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		DEC. 11, 1890		78 YRS		MONTHS 15		DAYS 15	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
New Jersey		United States		WIDOWED		DIVORCED		MONTGOMERY		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		CHERRY WILSON 94 CONV. CENTER		HOUSEWIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		4000 Columbia Ave. NW			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Julius		ELLIS						ANNE		GEE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				DAUGHTER		MRS JANICE GOLDBERG - 7835 ORCHID ST NW					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										2 days	
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
471X PARKINSONISM											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year		(Enter nature of injury in Part 1 or Part 2, Item 18)							
(If either, notify medical examiner)		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		Street or R.F.D. No.		City or Town		County		State	
at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from April, 1933, to Dec, 1968, that (I) (we) last saw the deceased alive on 12-26-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Marvin Fuchs		12-26-68		Marvin Fuchs		6201 Robin Wood Rd. Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		12-30-68		CEDAR HILL CEMETERY		WASHINGTON		DC			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
BERNARD DANZANSKY & SONS		WASHINGTON DC		JAN 2 1969		Charles Judge					



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VR A15-4,  
45M 1/69

17864

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17875

1 DECEASED-NAME (Type or print) First Middle Last <b>FRANCIS HENRY MAY</b>			2a. DATE OF DEATH Month Day Year <b>December 5 1968</b>		2b. HOUR <b>9:00 AM</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>September 2 1887</b>		6 AGE (in years last birthday) <b>81 YRS</b>	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>STATZIRLE N.Y.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>
10 CITY OR TOWN OF DEATH <b>OLNEY</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Brooke Grove Foundation</b>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>TRAFFIC SUPERVISOR</b>	
13a U.S.A. RESIDENCE (where deceased lived, if institution Residence before admission) STATE <b>New York</b>		13b COUNTY <b>Bronx</b>	13c CITY OR TOWN <b>Bronx</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>2908 Valentine Ave</b>
14 FATHER'S NAME First Middle Last <b>HARRY MAY</b>			15 MOTHER'S M.A.DEN NAME First Middle Last <b>ESTELLE T ROAL</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>067-03-0335</b>	7. INFORMANT Address <b>Mr. Gordon May 14804 Woburn Dr. Rockville Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute coronary</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cancer pancreas, inoperable</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with ascites &amp; obstructive jaundice</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-15"</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>mild anemia, malnutrition</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 8)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 20, 1968</b> to <b>Dec 5, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 22, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>John R. Spencer</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12-5-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>John R. Spencer</b>		22e. ADDRESS <b>Burton Columbia, Md and 4-170</b>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	
24. FUNERAL DIRECTOR <b>Tyson Heeler</b>		ADDRESS <b>1771 Rockville Pike Rockville, Md</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg. Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MAURICE			S.		MAY	12- 14- 1968		1:00 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		March 1, 1891		77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Wash. D. C.		U. S. A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			SUBURBAN			ARCHITECT			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		MONTGOMERY		CHEVY CHASE				3920 OLIVER STREET	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
GEORGE					MAY	ROSINA			SAUL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown?			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
NO			6-79-26 6803			MRS. EVELYN S. MAY			Same as #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left Humerus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 year</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Liver Disease with decompensation</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None		None			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
None		None		None					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
None		None							
22a. I certify that (I) (this hospital) attended the deceased from <u>September 1, 1967</u> , to <u>December 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
James M. Loftus M.D.									12/14/68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
JAMES M. LOFTUS					5415 CONN. AVE. N. W. WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		12-16-68		GATE OF HEAVEN		SILVER SPRING MD.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
COLLINS FUNERAL HOME ADDRESS					DEC 18 1968		Charles Judge		
500 UNIV. BLVD. W. SILVER SPRING, MARYLAND									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
17886										
17877										
1 DECEASED-NAME (Type or print) <b>WILLIAM</b>			First <b>S.</b> Middle <b>Mc</b> Last <b>Andrew</b>			2a DATE OF DEATH <b>12</b> Month <b>7</b> Day <b>68</b> Year		2b HOUR <b>6:30 P</b>		
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>Aug. 29, 1882</b>		6 AGE (In years last birthday) <b>86</b> YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>		Md.		
10. CITY OR TOWN OF DEATH <b>CHEY CHASE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BETHESDA SINCE SPRING NR. HAZAR</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Gov't. Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>DEMO.</b>		13b COUNTY <b>MONT.</b>		13c CITY OR TOWN <b>SUMNER</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5109 NAWANT ST. N.W.</b>		
14 FATHER'S NAME <b>ROBERT</b>			First <b>Simon</b> Middle <b>MARY</b> Last <b>C'DONOVAN</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>C'DONOVAN</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>579-60-1811-1</b>		17 INFORMANT <b>(DAUGHTER) MARY C. C'BEARNEY SHAFER-13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <b>Heart failure</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <b>Intermittent heart disease</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
MEDICAL CERTIFICATION										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>68</b> , to <b>Dec 7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Nov 25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>J. E. Fitzgerald</b>			22c. DATE SIGNED <b>12/7/68</b>			22d PHYSICIAN'S NAME (Type) <b>J. E. Fitzgerald</b>				
22e ADDRESS <b>3800 Reservoir Rd</b>										
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>12-10-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>LATE C'F HENRY CEM.</b>			23d LOCATION (City or Town) (County) (State) <b>WHEATON, MD.</b>	
24 FUNERAL DIRECTOR <b>H. Don</b>			24b ADDRESS <b>2222 WASH. D.C.,</b>			24c REC'D BY REGISTRAR <b>DEC 11 1968</b>			24d REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
24e NAME (Type) <b>DEVOL'S</b>			24f ADDRESS <b>WISCONSIN AVE.</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First		Middle		Last		Month		Day		Year	
LILA J. McCathran						Dec.		28		1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		4-12-1874		94 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
VA.		U.S.A.				MONTGOMERY Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
Kensington				Kensington Gardens Spair				House wife			
12b. KIND OF BUSINESS OR INDUSTRY				13a. INSIDE CITY LIMITS?				13b. STREET AND NUMBER			
AT HOME				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2810 HARDY AVE			
13c. CITY OR TOWN				14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Wheaton				THOMAS W. ANDERSON				ELIZA - CANNON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
NO				215-54-5143				G. Farrell Ror. (Hospital records)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ASHD & H CVD											
4120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 443X											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
AS cerebro-vasc. disease secondary anemia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION			
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8-27-1967 to 12-28-1968, that (I) (the) last saw the deceased alive on 12-22-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED			22d. ADDRESS		
G. F. SENGSTACK MD						12-28-68			9241 COL. BLVD., SILVER SPRING, MD		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			22f. DATE		
G. F. SENGSTACK						9241 COL. BLVD., SILVER SPRING, MD			JAN 2 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)	
BURIAL				12/31/68		CONGRESSIONAL CEM.				WASHINGTON, D.C.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
JOS. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.						DATE JAN 2 1969			J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17893

CERTIFICATE OF DEATH

17879

1 DECEASED-NAME (Type or print) <i>Elizabeth Bliss McClelland</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>22</i> Year <i>1968</i>			2b. HOUR <i>2:15</i> M			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>6/27/14</i>		6 AGE (In years last birthday) <i>54</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTH-PLACE (State or foreign country) <i>Idaho</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Md
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>			12b KIND OF BUSINESS OR INDUSTRY	
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Potomac</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>10821 Edison Rd.</i>	
14. FATHER'S NAME First Middle Last <i>George H Bliss</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth Luxbury</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input type="checkbox"/> or Unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>-</i>
17 INFORMANT <i>Husband Glenn McClelland</i>			Address <i>Same as above</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute cardiac arrest</i> <i>4 hours</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypoxia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Mucus plugs and aspirated vomitus in bronchioles</i> <i>2 hours</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4</i> (d) <i>Pneumonia, pulmonary atelectasis</i>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a Autopsy? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>12-13</i> , 1968, to <i>12-23</i> , 1968, that (I) (we) last saw the deceased alive on <i>12-23</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>W. G. Hall</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>12/23/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>W. G. Hall</i>					22e ADDRESS <i>615 West Montgomery Avenue, Rockville, Maryland</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>12-26-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville, Montgomery Co., Md.</i>			
24 FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>					25a REC'D BY REGISTRAR DATE <i>DEC 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Michael Allen McCluskey						DATE MATED <input checked="" type="checkbox"/> Dec. 31 1968		10 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
M.	W.	Sept 4, 1961	YRS 3	MONTHS 27	DAYS	HOURS	MIN	Month Day Year	2d HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Montgomery		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Monrovia			Route 1 Gladhill Rd.						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			Montgomery			Monrovia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			Route 1 Gladhill Rd.			
Harry McCluskey			Genda Lowe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No						Harry L. McCluskey, Jr. Monrovia, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia - viral</u> -									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
480X DUE TO, OR AS A CONSEQUENCE OF									24h.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
492x									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
John G. Ball			John G. Ball, M.D.					Dec. 31, 1968.	
ADDRESS			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 2, 1969		Seals Cemetery		Elchison, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Olin L. Molesworth, Damascus, Md.						DATE JAN 6 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when proper remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

17870		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17881	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) <i>Horace L. McCoy Jr.</i>			2a DATE OF DEATH Month <i>Dec.</i> Day <i>30</i> Year <i>1968</i>			2b HOUR <i>5:30 PM</i>	
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>11/9/19</i>		6 AGE (In years last birthday) <i>49</i> YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Retarded</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>mont. Charyches</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY, Y.N. YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>3802 Washington St.</i>		14. FATHER'S NAME First <i>Horace L.</i> Middle <i>McCoy</i> Last <i>McCoy</i>		15. MOTHER'S M.A.D.E.N. NAME First <i>Evelyn</i> Middle <i>McCoy</i> Last <i>McCoy</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>	
16b SOCIAL SECURITY NO <i>None</i>		17 INFORMANT <i>Evelyn McCoy</i>		Address <i>Same as Item 13.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma, PANCREAS</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>157X</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>December 16, 1968</i> , to <i>Dec 30</i> , 1968, that (I) (we) last saw the deceased alive on <i>Dec 30</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>W.T. Marcus MD</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED <i>1-2-69</i>	
22d PHYSICIAN'S NAME (Type) <i>Wm. T. Marcus</i>				22e ADDRESS <i>10620 Georgia Ave. Silver Spring, Md.</i>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>Cremation 1-3-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>JAN 6 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17871					17882				
1 DECEASED-NAME (Type or print)					2a DATE OF DEATH				
First Middle Last					Month Day Year				
BERTHA					December 7 1968				
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7b HOUR	
Female		White		10-19-05		63 YRS		10:55 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. MONTHS	
Mo.		American				Montgomery		DAYS	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a STREET AND NUMBER	
Toloma Park		Washington Son. Hosp.		HELPER		The Falls Church, VA.		7447 Ivywood Rd.	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Virginia				Falls Church					
14 FATHER'S NAME First Middle Last			5 MOTHER'S MAIDEN NAME First Middle Last						
William FIRTH			Edwards						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
No			578-54-3199			Hospital Records, Toloma Park, Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Edema									
1621 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma metastatic to the brain (multiple) unknown									
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lower lobe of left lung unknown									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1632									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e ADDRESS		22c. DATE SIGNED			
Seruch T. Kimble		Seruch T. Kimble		9801 Virginia Ave, Falls Church, Va.		12-7-68.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/10/68		National Mem. Park		Falls Church, Fairfax, Va.			
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Pearson's Funeral Home		DEC 12 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Paul William McCULLAGH, Jr.						7 December 1968		11:50 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Cauc		7 December 1968		YRS.		0 40		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Montgomery		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia			Arlington		Arlington		YES		1830 Columbia Pike, Apt 510	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Paul William McCULLAGH			Donna L. DEMPSTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT					
NO			NONE		1830 Columbia Pike Apt 510 Paul W. McCULLAGH Arlington, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atelectasis, bilateral compatible with hyaline membrane disease</u> 7761 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 December 1968, to 7 December 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 December 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>G. P. Schwartz</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9 December 1968			
22d. PHYSICIAN'S NAME (Type) G. P. SCHWARTZ, M. D.					22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12-11-68		Summit View Cemetery		Guthrie (Logan) Oklahoma				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.					25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408 Maryland State Department of Health  
1-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

178-3

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17884

1. DECEASED-NAME (Type or Print) <b>McDowell George Joseph McDowell</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>18</b> YEAR <b>1968</b>		2b. HOUR <b>8:45 AM</b>
3 SEX <b>Male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>1-5-11</b>	6 AGE (In years last birthday) <b>57</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Montgomery</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Amer</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>* Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Church</b>
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Wash. D.C.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>George</b> Middle <b>McDowell</b> Last <b>McDowell</b>		15. MOTHER'S MAIDEN NAME First <b>Bridgett</b> Middle <b>McGlynn</b> Last <b>McGlynn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>hosp record</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple extreme internal injuries</b> <b>516.0</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with exsanguination incurred in</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>34</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>10:30 AM 12-16 1968</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Deceased, driving alone, lost control of auto which left road, and struck pole.</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>	21f. LOCATION Street or R.F. No. <b>Wash. D.C.</b>	City or Town <b>Wash. D.C.</b>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <b>Belden R. Reap M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>DEC. 18, 1968</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>	ADDRESS <b>254 Carroll Rd N.W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 21, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Montgomery Co. Md.</b>	25. REC'D BY REGISTRAR <b>DEC 13 1968</b>
24. FUNERAL DIRECTOR <b>Takoma Funeral Home Inc. J. Arthur Walters</b>		25. REGISTRAR'S SIGNATURE <b>J. Arthur Walters</b>		



# FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print) <i>Ruth C. McEune</i>						2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>12-9 1968</i>		2b HOUR <i>30</i>		2c DATE PRONOUNCED DEAD <i>12 9 1968</i>		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>4/12/96</i>		6 AGE (In years last birthday) <i>72 YRS</i>		IF UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>28</i>		IF UNDER 24 HRS HOURS <i></i> MIN <i></i>		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Home Market</i>						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>				13b COUNTY <i>Mont. Kensington</i>				13c CITY OR TOWN <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>		13d INSIDE CITY LIMITS?		
14 FATHER'S NAME First <i>Michael</i> Middle <i>Joseph</i> Last <i>Corbett</i>				15 MOTHER'S MAIDEN NAME First <i>Marcia</i> Middle <i>Tobey</i> Last <i>Tobey</i>				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16b SOCIAL SECURITY NO <i>217-466 19A</i>				17 INFORMANT <i>Daughter - Betty Jane Corbett</i>				18 ADDRESS <i>Bethesda, Md.</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency Acute -</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular Disease</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio Sclerosis Generalized</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fracture of Rt Hip</i>												
19a DATE OF OPERATION <i>Nov 28, 1968</i>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Nailing of Fract. Rt Hip</i>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>8:00 AM Nov 27, 1968</i>				21b TIME OF INJURY Month, Day, Year <i>Nov 27, 1968</i>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell at home causing fracture of hip</i>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) <i>Home</i>				21f LOCATION Street or R.F.D. No. <i>3506 Nimitz Rd</i> City or Town <i>Kensington</i> County <i>Montgomery</i> State <i>Md</i>				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <i>Dec 9, 1968</i>				
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>												
23a BURIAL OR CREMATION <i>REMOVED</i>		23b DATE <i>12-12-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Ammondale Christian</i>				23d LOCATION (City or Town) (County) (State) <i>Brookville Prince Georges Md.</i>				
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Beth., Md.</i>						25a REC'D BY REGISTRAR DATE <i>DEC 16 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 5 14  
45M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <u>Samuel</u> First <u>McKaig</u> Middle <u>McKaig</u> Last						2a. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1968</u>			2b. HOUR <u>11 A</u> MIN <u>45</u>		
3 SEX <u>male</u>		4 RACE <u>negro</u>		5 DATE OF BIRTH <u>??</u> <u>1881</u>		6 AGE (in years last birthday) <u>87</u> YRS.		7 UNDER YEAR MONTHS <u>11</u> DAYS <u>11</u>		7 UNDER 24 HRS. HOURS <u>11</u> MIN <u>45</u>	
7a BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u> Md.					
10 CITY OR TOWN OF DEATH <u>Bethesda</u>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>laborer</u>			12b KIND OF BUSINESS OR INDUSTRY <u>farm.</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md</u>			13b COUNTY <u>Mont</u>			13c CITY OR TOWN <u>Bethesda</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>Rt #2</u>	
14 FATHER'S NAME First <u>Joseph</u> Middle <u>McKaig</u> Last				15 MOTHER'S MAIDEN NAME First <u>Hester</u> Middle <u>Thompson</u> Last							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)				16b SOCIAL SECURITY NO. <u>214-3011397</u>		17 INFORMANT <u>William H. Bland</u> Address <u>4401 - State St. - Wash.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u>											
4d 10 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4d 10</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. <u>19</u> Month <u>12</u> Day <u>11</u> Year <u>1968</u>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. <u>5415 W. Cedar Lane</u>			21f LOCATION City or Town <u>Bethesda</u> County <u>Md.</u> State <u>Md.</u>		
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>68</u> , to <u>Dec 11</u> , 19 <u>68</u> ; that (I) (we) last saw the deceased alive on <u>Dec 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Stewart Clapp M.D.</u> DEGREE <u>M.D.</u>						22c DATE SIGNED <u>12 13 68</u>					
22d PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>						22e ADDRESS <u>5415 W. Cedar Lane Bethesda Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b DATE <u>12-18-68</u>			23c NAME OF CEMETERY OR CREMATORY <u>Martinsburg Cemetery</u>			23d LOCATION (City or Town) <u>Martinsburg</u> (County) <u>Montg</u> (State) <u>Md.</u>		
24 FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville Md.</u>						25a REC'D BY REGISTRAR <u>DEC 20 1968</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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VR A  
30A REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Emma Marie Mc Veary</i>						2a. DATE OF DEATH Month Day Year <i>12 7 68</i>		2b. HOUR <i>11:40 a</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/30/96</i>		6. AGE (In years last birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md			
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Holy Cross</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own home</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>12804 Matey Road</i>	
14. FATHER'S NAME First Middle Last <i>Henry G. Wienecke</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Emma -- Becker</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>no</i>		16b SOCIAL SECURITY NO. <i>577-48-7913</i>		17. INFORMANT <i>Emma De Simone</i>		Address <i>12806 Matey Road, S.S., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Insufficiency</i> 41-2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute Myocardial Infarction</i> 48hr DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary atherosclerosis</i> at 2 yr								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4 None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>65</i> , to <i>Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Dec 1</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ralph E. Patten</i>				DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>12/1/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>RALPH E. PATTEN</i>				22e. ADDRESS <i>407 Woodland Highway</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>12-4-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>			
24 FUNERAL DIRECTOR <i>M. Andrew Dunall</i>				ADDRESS <i>Sil. Spr. Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	
Warner E. Pumphrey, Inc. 8434 Georgia Avenue									



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17888

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17888

1. DECEASED-NAME (Type or print) First Middle Last <b>SENA P. MEDILL</b>			2a. DATE OF DEATH Month Day Year <b>12 3 68</b>			2b. HOUR <b>1:30 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11-6-87</b>		6. AGE (in years last birthday) <b>81</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>NEB.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County Md.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>12919 Valleywood Dr.</b>		14. FATHER'S NAME First Middle Last <b>Soren -- Schmidt</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Karen --- Jensen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>526-26-8897</b>		17. INFORMANT <b>Mrs. Charles Kinahan</b>		Address <b>Sil. Spr. Md. 12919 Valleywood Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>							<b>MINUTES</b>
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b>							<b>3 DAYS</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC ARTERIO-SCLEROSIS</b>							<b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CEREBRAL VASCULAR ACCIDENT; HYPERGLYCEMIA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>November, 1968</b> , to <b>12/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold W. Draper</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER M.D.</b>				22e. ADDRESS <b>9801 GEORGIA AVE, Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>12-7-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cemetery</b>		23d. LOCATION (City or Town) (State) <b>Rock Springs Sweetwater Wyoming</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>				ADDRESS <b>Sil. Spr. Md. Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>DEC 3 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			

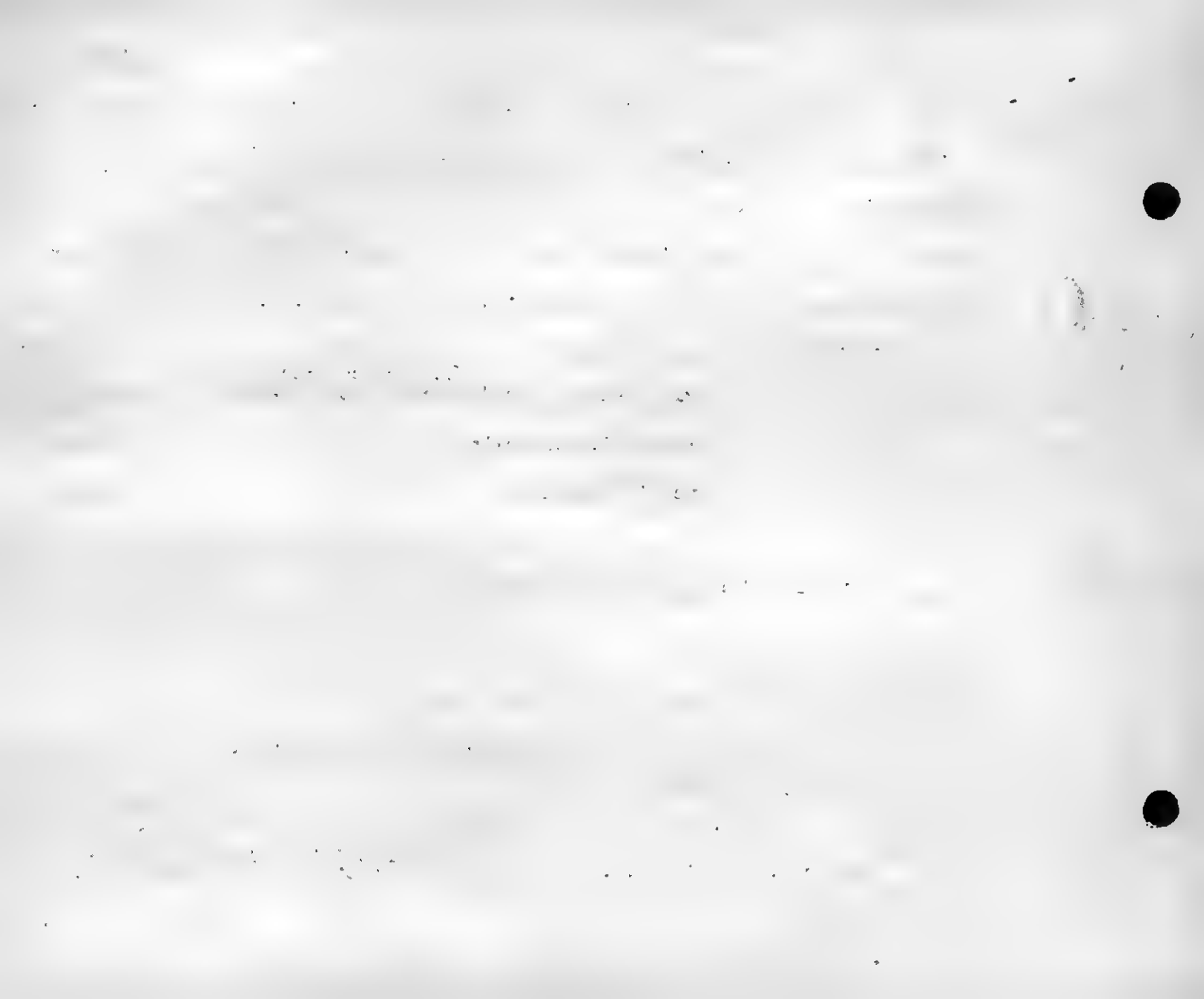


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>John Bruce Mentzer</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR <b>1:55 P.M.</b>			
3. SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>1 July 1914</b>		6. AGE (in years lost birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Usual: Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Pennsylvania</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Newville</b>		13d. INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R. D. # 2</b>	
14. FATHER'S NAME First Middle Last <b>Bruce Mentzer</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Bertha Souders</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-03-2424</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Progressive Cachexia</b> <i>due to</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Mycosis Fungoides</b> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> <b>10 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>History of coronary artery disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>1</b>					
22a. I certify that (A) (this hospital) attended the deceased from <b>February 7, 1968</b> , to <b>December 1, 1968</b> , that (X) (we) last saw the deceased alive on <b>December 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Ervin Epstein, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>2 December 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Ervin H. Epstein, M.D.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION (City or Town) <b>umbagog</b> (County) <b>nd</b> (State) <b>Levenshore Farm Hip Pa.</b>			
24. FUNERAL DIRECTOR <b>Lyson Heeler Funeral Home</b> ADDRESS <b>1331 Rockville</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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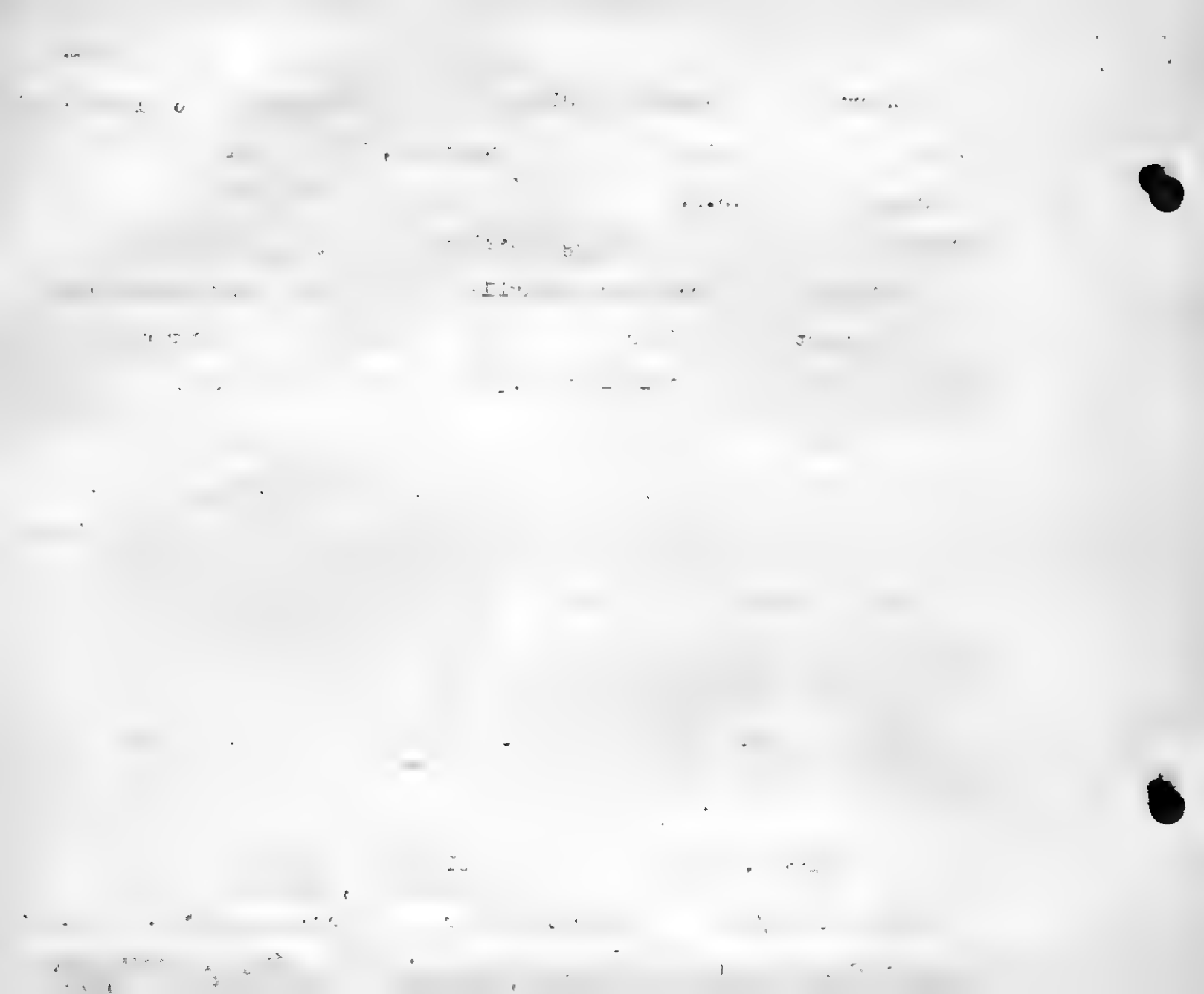
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>ANGELLO</b> <b>S.</b> <b>MESSINA</b>			2a. DATE OF DEATH <b>DEC</b> Month <b>2</b> Day <b>68</b> Year			2b. HOUR <b>8:30 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10 JUNE 1911</b>		6. AGE (in years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery City</b> Md.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>INT. TEL. &amp; TEL.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSURE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>8508-16 ST.</b>	
14. FATHER'S NAME <b>CHARLES</b> <b>MESSINA</b>			15. MOTHER'S MAIDEN NAME <b>ROSE GUGLISI</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-65-8396</b>		17. INFORMANT <b>Hosp Records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYCARDIAL INFARCTION</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4107</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1968</b> , to <b>12-2, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Dec 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Robert Kramer</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/2/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>ROBERT KRAMER</b>				22e. ADDRESS <b>8484-16 ST. SS. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5 DEC. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BERTLIN COLN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENBURG MD.</b>			
24. FUNERAL DIRECTOR <b>RINALDI FUNERAL HOME INC.</b>		ADDRESS <b>7406 GEORGE AVE. N.W.</b>		25a. RECEIVED BY REGISTRAR <b>DEC 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17891										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17891									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last <b>Harry Norman Miles</b>										Month Day Year <b>December 28 1968</b>										4:30 AM									
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>August 27, 1887</b>			6. AGE (in years lost birthday) <b>81</b> YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md																				
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>263 Congressional</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Courthouse Employee</b>			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Rockville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>263 Congressional Lane</b>																	
14. FATHER'S NAME First Middle Last <b>Herbert Miles</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>Jenny (Unknown)</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>			16b. SOCIAL SECURITY NO. <b>218-38-8260</b>			17. INFORMANT <b>Wife</b>			Address <b>( Above )</b>																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Artemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>20 years</u> <u>15 years</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15</u> , 19 <u>68</u> , to <u>12/28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>W. P. Hall</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>12/28/68</u>																			
22d. PHYSICIAN'S NAME (Type) <b>William G. Hall</b>										22e. ADDRESS <b>615 West Montgomery Avenue</b> <b>Rockville, Maryland</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>12/31/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Damascus Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Damascus Montg. Maryland</b>														
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>										ADDRESS <b>1331 Rockville</b> <b>Rockville, Maryland</b>					25a. REC'D BY REGISTRAR <b>Pk. JAN 3 1969</b>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Marion W. Milne</i>						2a. DATE OF DEATH Month <i>December</i> Day <i>26</i> Year <i>1968</i>			2b. HOUR <i>2:56</i> M <i>PM</i>		
3 SEX <i>F</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>4-30-08</i>		6 AGE (In years last birthday) <i>60</i> YRS		7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8 IF LIVED 1 YRS HOURS <i>0</i> MIN <i>0</i>	
7a BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>				13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Bethesda</i>		13d HOME CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>8305 Woodhawn</i>	
14 FATHER'S NAME First <i>Charles</i> Middle <i>Leino</i> Last <i>Leino</i>				15 MOTHER'S MAIDEN NAME First <i>Anne</i> Middle <i>Stevens</i> Last <i>Stevens</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <i>577-44-2575</i>		17 INFORMANT Address <i>James and above</i> <i>Alexander M. Milne</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Calcific aortic stenosis</i> <i>3950</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Rheumatic fever</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs</i> <i>25 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>A.S.H.D. = Myocardial Infarct, Remote (18 mo)</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>12</i> Day <i>26</i> Year <i>1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No <i>4709</i> City or Town <i>Montgomery</i> County <i>La.</i> State <i>Bethesda</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>1944</i> to <i>12/26</i> , 19 <i>68</i> , that (I) (we) lost the deceased on <i>12-26-68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Paul D. Cantor</i>				DEGREE <i>MD</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>12/27/68</i>					
22a. PHYSICIAN'S NAME (Type) <i>PAUL D. CANTOR</i>				22e. ADDRESS <i>4709 Montgomery La. Bethesda, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>12-30-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) <i>Suitland</i> (County) <i>Maryland</i> (State)					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Md.</i>				25a. REC'D BY REGISTRAR <i>JAN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>JOHN ROBERT MOORE, SR.</b>						2a. DATE OF DEATH Month Day Year <b>12 24 68</b>			2b. HOUR A <b>11:10</b>		
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>1/24/04</b>		6. AGE (In years lost birthday) <b>64 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>64</b>		IF UNDER 24 HRS. HOURS MIN <b>11:10</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>OLNEY</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TRUCK DRIVER, RETIRED</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>			13b. CITY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT#3, QUINCE ORCHARD RD.</b>		
14. FATHER'S NAME First Middle Last <b>JOHN HENRY MOORE</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>HATTIE --- BRANDSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>MEDICAL RECORDS</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4 days											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Coronary Thromboses</b> 4 days											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis of Coronary?</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Gen'l. Arteriosclerosis</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1961</b> , 19, to <b>Dec. 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jack Schumacher</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-25-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M.D.</b>						22e. ADDRESS <b>105 RUSSELL AVE. GAITHERSBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>12-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Bapt. Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Darnestown Mtd. Md.</b>				
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>			ADDRESS <b>Rockville, Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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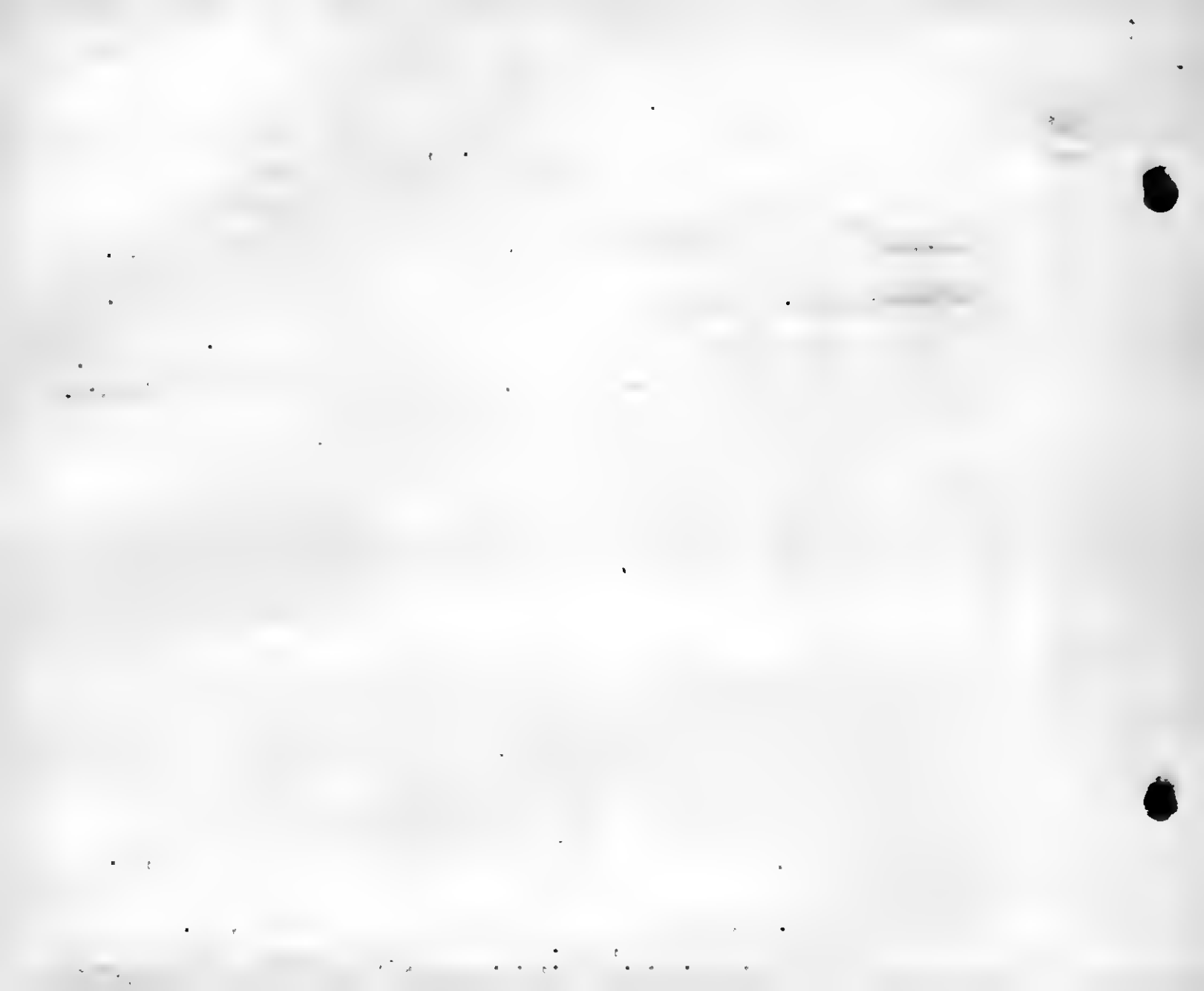
17893		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17894	
1. DECEASED-NAME (Type or print)			First	Middle	Last
THOMAS			P.		MORGAN
3. SEX	4. RACE	5. DATE OF BIRTH	2a. DATE OF DEATH		
M	White	12/27/04	Month Dec.	Day 12	Year 1968
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6. AGE (in years last birthday)	2b. HOUR	
D.C.	USA		63 YRS.	1040	PM
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	Holy Cross Hosp	MONTGOMERY		PERSONNEL Aide Agric. Dept.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Md.	MONT.	S.S.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12403 FELDON ST.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			
HENRY WILLIAMS	LOUISE HERR	YES <input checked="" type="checkbox"/> W.W.II			
16b. SOCIAL SECURITY NO		17. INFORMANT			
217-44-0035		C. BRENT MORGAN 823 S. ROYAL ST. ALEXANDRIA, VIRGINIA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) massive Right Cerebral Hemorrhage					1 wk
4327 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis + Obstruction Right and Left					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Internal Carotid Artery, Complete					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN BY PART 1 (a) Atherosclerosis + Partial Obstruction Vertebral Artery					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
1/24/68 + 11/27/68	Obstruction Carotid Artery	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
	HOUR A.M. Month Day Year P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION	21g. CITY OR TOWN		
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		Street or RFD No.	City or Town		
22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1968, to 12/12, 1968, that (I) (we) last saw the deceased alive on 12/12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE	22c. DATE SIGNED	22d. PHYSICIAN'S NAME (Type)			
Martin D. Schenck MD	12/13/68	22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Cremation	12/15/68	Lee's Crematory	Washington, D.C.	20002	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home		DEC 19 1968		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>17894</div> <div>CERTIFICATE OF DEATH</div> <div>17895</div>											
1. DECEASED-NAME (Type or print) <b>SARAH S. MORRIS</b>						2a. DATE OF DEATH <b>Dec 21 1968</b>		2b. HOUR <b>8:45 A M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Oct. 2, 1879</b>		6 AGE (In years last birthday) <b>89 YRS</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>			Md		
10 CITY OR TOWN OF DEATH <b>Wheaton</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wheaton Nursing Home</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>School Teacher</b>		12b KIND OF BUSINESS OR INDUSTRY <b>D.C. Schools</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>				13b CITY OR TOWN <b>Bethesda</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>4800 Bradley Blvd.</b>			
14a FATHER'S NAME First <b>Stephen</b> Middle <b>W.</b> Last <b>Morris</b>				15 MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>G.</b> Last <b>Crawford</b>				Ave. <b>Bethesda, Md.</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b SOCIAL SECURITY NO <b>220-44-3492</b>		17 INFORMANT <b>Dr. Albert Bright</b> Address <b>4809 Broad Brook Rd., Bethesda, Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <b>19</b> P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or RFD No _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital), attended the deceased from <b>Dec 20, 1968</b> , to <b>Dec 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Fred A. Gill, M.D.</b> DEGREE <b>M.D.</b>						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>Dec. 21, 1968</b>			
22d PHYSICIAN'S NAME (Type) <b>Fred A. Gill</b>		22e ADDRESS <b>4743 Bradley Blvd., Bethesda, Md.</b>									
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b DATE <b>Dec. 23, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d LOCATION (City or Town) <b>Suitland, Md.</b>		(County) _____ (State) _____			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5150 Wisc. Ave. N.W. Wash., D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>17895</div> <div>CERTIFICATE OF DEATH</div> <div>17896</div>									
1. DECEASED-NAME (Type or print) <b>Stephen (n) MORRIS</b>					2a. DATE OF DEATH 8 December 1968			2b. HOUR 1:20AM	
3 SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH <b>November 13, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>U. S. Army</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Tennessee</b>			13b. COUNTY <b>Memphis</b>		13c. INS. DE CITY, TOWNSHIP <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>505 S. Perkins</b>		
14. FATHER'S NAME First Middle Last <b>Lindsey MORRIS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sara RITTENHOUSE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>VW 1&amp;2, Korea</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Ann MORRIS, 505 S. Perkins, Memphis, Tenn.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>1631</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1631</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1 December, 1968</b> , to <b>8 December 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8 December 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arthur Lynel Graybiel</b>					DEGREE <b>MD</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) <b>A. L. GRAYBIEL, LCDR MC USN</b>					22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>12/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>J. WILLIAM LEE'S SONS CO.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>		23e. REGISTRAR'S SIGNATURE <b>20002</b>	
24. FUNERAL DIRECTOR <b>J. WILLIAM LEE'S SONS CO.,</b>					ADDRESS <b>Washington, D. C.</b>		DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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17896										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17897									
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last GEORGE A. MOSE										Month Day Year DECEMBER 3 1968										755A M									
3 SEX MALE					4 RACE CAUCASIAN					5 DATE OF BIRTH APRIL 17, 1914					6 AGE (In years last birthday) 54 YRS					7 UNDER 1 YEAR MONTHS DAYS HOURS MIN					8 UNDER 24 HRS HOURS MIN				
7a BIRTHPLACE (State or foreign country) DIST. OF COLUMBIA					7b CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9 COUNTY OF DEATH MONTGOMERY Md														
10 CITY OR TOWN OF DEATH BETHESDA					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL					12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) U.S.N.					12b KIND OF BUSINESS OR INDUSTRY N/A														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address) STATE DIST. OF COLUMBIA					13b COUNTY WASHINGTON					13c CITY OR TOWN WASHINGTON					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER WASHINGTON, D.C. 1739 Q ST., N.W.									
14 FATHER'S NAME First Middle Last ROBERT MOSE										15 MOTHER'S MAIDEN NAME First Middle Last LELIA MEREDITH																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16b SOCIAL SECURITY NO 225-46-5738					17. INFORMANT 12912 ALLERTON LAINE Address ORVILLE S. MOSE SILVER SPRINGS, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute gastrointestinal hemorrhage secondary to</u> <u>multiple small bowel ulcerations</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>578x</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV. 16</u> , 19 <u>68</u> , to <u>DEC. 3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>DEC. 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death																													
22b. SIGNATURE <u>John S. Ratliffe M.D.</u>										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED December 4, 1968														
22d. PHYSICIAN'S NAME (Type) John S. Ratliffe, M.D.										22e. ADDRESS Naval Hospital, Bethesda, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE Dec 6, 1968					23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY					23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA														
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS, HYATTSVILLE, MD.										25a. REC'D BY REGISTRAR DATE DEC 9 1968					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														





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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR PM		
Lisa Anne Moulson						December 31, 1968			11:45 AM		
3. SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		July 3, 1962		6 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New York		USA				Montgomery Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY --		
Bethesda			The Clinical Center, NIH			Child					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Georgia			--		Atlanta		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		310 Lake Placid Drive		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Robert Lewis Moulson						Darlene Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT					
No			None			The Medical Record Address The Clinical Center, Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheal obstruction by tumor mass</u> <u>2040</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Lymphocytic Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u>  <u>9 Months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>2040</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) Office building, etc.		21f. LOCATION Street or R.F.D. No. City or Town County State							
				31							
22a. I certify that (M) (this hospital) attended the deceased from <u>December 28, 1968</u> , to <u>December 31, 1968</u> , that (H) (we) last saw the deceased alive on <u>December 31, 1968</u> , and that in (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (M) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harmon J. Eyre M.D.</u> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1 January 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>Harmon J. Eyre, M. D.</u>						22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/2/69		Arlington Cemetery		Foulton County Georgia					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland						JAN 6 1969		<u>Charles Judge</u>			



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17888

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17889

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>Evelyn Anne Muller</b>			2a DATE OF DEATH Month Day Year <b>December 6 1968</b>			2b HOUR <b>8:15 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>November 17, 1926</b>		6 AGE (In years last birthday) <b>42 YRS</b>	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium - Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived if in institution. Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Rockville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>14608 Woodcrest Drive</b>		14. FATHER'S NAME First Middle Last <b>JESSE James Sublet</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b SOCIAL SECURITY NO. <b>UNKNOWN</b>		17 INFORMANT <b>Records - Washington Sanitarium &amp; Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> HOURS							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY ARTERY ANEURYSM</b> HOURS?							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGENITAL HEART DISEASE - AORTIC</b> YRS.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DEFECT</b>							
<b>7.4.5 COLLAGEN DISEASE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 1963</b> , to <b>DEC. 6, 1968</b> , that (I) (we) lost saw the deceased alive on <b>DEC. 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Albert H. Grollman</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ALBERT H. GROLLMAN</b>				22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>12/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Funeral Home</b>				ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 9 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>John A. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17899

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17900

1 DECEASED NAME (Type or print) <i>Bernard Myers</i>		First <i>last</i>		2a DATE OF DEATH Month <i>Dec</i> Day <i>28</i> Year <i>1968</i>		2b. HOUR <i>11:45</i> M	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Feb 8, 1920</i>		6 AGE (In years last birthday) <i>48</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Photographer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self. photo</i>	
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <i>9935 Silver Brook Dr.</i>		14 FATHER'S NAME First Middle Last <i>Bernard Myers Sr.</i>		15 MOTHER'S M.A.D.E.N NAME First Middle Last <i>Olive Potter</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give year and dates of service) <i>No</i>		16b SOCIAL SECURITY NO. <i>411-1940</i>		17 INFORMANT <i>Yvonne Myers wife of deceased</i>		Address <i>same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i>							<i>minutes</i>
410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerosis</i>							<i>years</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION <i>7</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 7, 1968</i> , to <i>Dec 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alfred L. Norton</i> M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>Dec 28 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Alfred L. Norton</i>				22e. ADDRESS <i>7710 Dwight Dr. Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Dec 31, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Md. 20014</i>				25a. REC'D BY REGISTRAR <i>JAN 6 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



17850

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17961

1. DECEASED NAME (Type or print) <b>DAWN</b>		First <b>R.</b>		Middle <b>MYERS</b>		Last <b>MYERS</b>		20. DATE OF DEATH <b>12</b> <b>20</b> <b>68</b>		2b. HOUR <b>9:05A</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>7/3/67</b>		6 AGE (In years lost birthday) <b>17</b> <b>08</b> <b>8</b>		7. IF UNDER 1 YEAR MONTHS <b>17</b> DAYS <b>4</b>		8. IF UNDER 24 HRS HOURS <b>17</b> MIN <b>4</b>	
7a. BIRTHPLACE (State or foreign country) <b>Sil. Sprg,</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired ) <b>minor</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Beltville</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>11216 Evans Trail, Belts.</b>			
14. FATHER'S NAME <b>Kenneth</b>		First <b>Wayne Myers</b>		Middle <b>Patricia</b>		Last <b>Anne Bailey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>none</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>father Kenneth 11216 Evans Trail Belts Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Congenital anomalies</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hydrocephalus and Meningo-encephalocele</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>7512</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/68</b> , 19____, to <b>12/2/68</b> , that (I) (we) last saw the deceased alive on <b>12/1/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Stanley H. Steinberg, M.D.</b>		DEGREE		22c. DATE SIGNED <b>12/2/68</b>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>1040 UNIVERSITY BLVD. E. SILVER SPRING, MARYLAND</b>									
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE <b>Dec 4-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lucian</b>		23d. LOCATION (City or Town)		County		State	
24. FUNERAL DIRECTOR <b>St. Lawrence &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Phyllis Jones</b>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

closed with a Resp. mask

MEDICAL CERTIFICATION





17902

1. DECEASED NAME (Type or print) <b>Louis Hugh Nance</b>		First		Middle		Last		2a. DATE OF DEATH Month <b>Dec</b> Day <b>30</b> Year <b>1968</b>		2b. HOUR <b>8:15</b> PM	
3. SEX <b>male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>6/19/1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>University Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Procurement Officer Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2921 Stanton Ave.</b>			
14. FATHER'S NAME First <b>John</b>		Middle <b>S.</b>		Last <b>Nance</b>		15. MOTHER'S MAIDEN NAME First <b>Martha</b>		Middle <b>Jane</b>		Last <b>Green</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or dates of service) <b>Yes</b>		16b. SOCIAL SECURITY NO <b>215-16-9123</b>		17. INFORMANT Name <b>Nance</b> Address <b>2921 Stanton Avenue, Silver Spring, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive Heart Failure</b> <b>4-1X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia, probably viral</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>2 months</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>2 months</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAME DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerosis - Senility</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>at work</b>							
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>at work</b>		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>61</b> , to <b>Dec 30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Philip E. Jones M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/30/68</b>	
22a. PHYSICIAN'S NAME (Type) <b>Philip E. Jones</b>		22e. ADDRESS <b>800 Pershing Drive Silver Spring, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Interment</b>		23b. DATE <b>2-3-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland Pr. Geos., Md.</b>		(County)		(State)	
23e. EXEMPT DIRECTOR <b>Warner E. Humphrey, Inc. 8434 Georgia Avenue</b>		23f. ADDRESS <b>Sil. Spr. Md.</b>		23g. REC'D BY REGISTRAR <b>JAN 6 1969</b>		23h. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



## CERTIFICATE OF DEATH

17903

1. DECEASED-NAME (Type or print) <b>May</b>		First <b>May</b>		Middle <b>Neidorf</b>		Last <b>Neidorf</b>		2a. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>10<sup>00</sup> A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Aug 8, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery - Md.</b>					
10. CITY OR TOWN OF DEATH <b>Wheaton, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Randolph Hills Nursing Home</b>		12a. USJAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) <b>TAILOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>					
13a. USJAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2900 MILITARY RD. N.W.</b>			
14. FATHER'S NAME First <b>Alexander</b> Middle <b>Neidorf</b> Last <b>Neidorf</b>		15. MOTHER'S MAIDEN NAME First <b>Freda</b> Middle <b>Neidorf</b> Last <b>Neidorf</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>160-10-1134</b>		17. INFORMANT <b>Harvey Neidorf</b> Address <b>2900 MILITARY RD. N.W. WASHINGTON, D.C.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b>										<b>1 month</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>										<b>6 yrs</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus, Ulcer, Sclerotic Heart Disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>7</b> Year <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or P.O. No. <b>9411 George Ave</b> City or Town <b>Silver Spring</b> County <b>Montgomery</b> State <b>Md.</b>							
22a. I certify that (A) (this hospital) attended the deceased from <b>Sept 1, 1967</b> to <b>Dec 7, 1968</b> , that (B) (we) lost saw the deceased of ve on <b>5 Dec 1968</b> , and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Morton White M.D.</b>		22c. DATE SIGNED <b>7 Dec 68</b>									
22d. PHYSICIAN'S NAME (Type) <b>MORTON WHITE, M.D.</b>		22e. ADDRESS <b>9411 George Ave Silver Spring Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-9-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NAT'L MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FALLS CHURCH VA.</b>					
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		ADDRESS <b>4219 2nd St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician

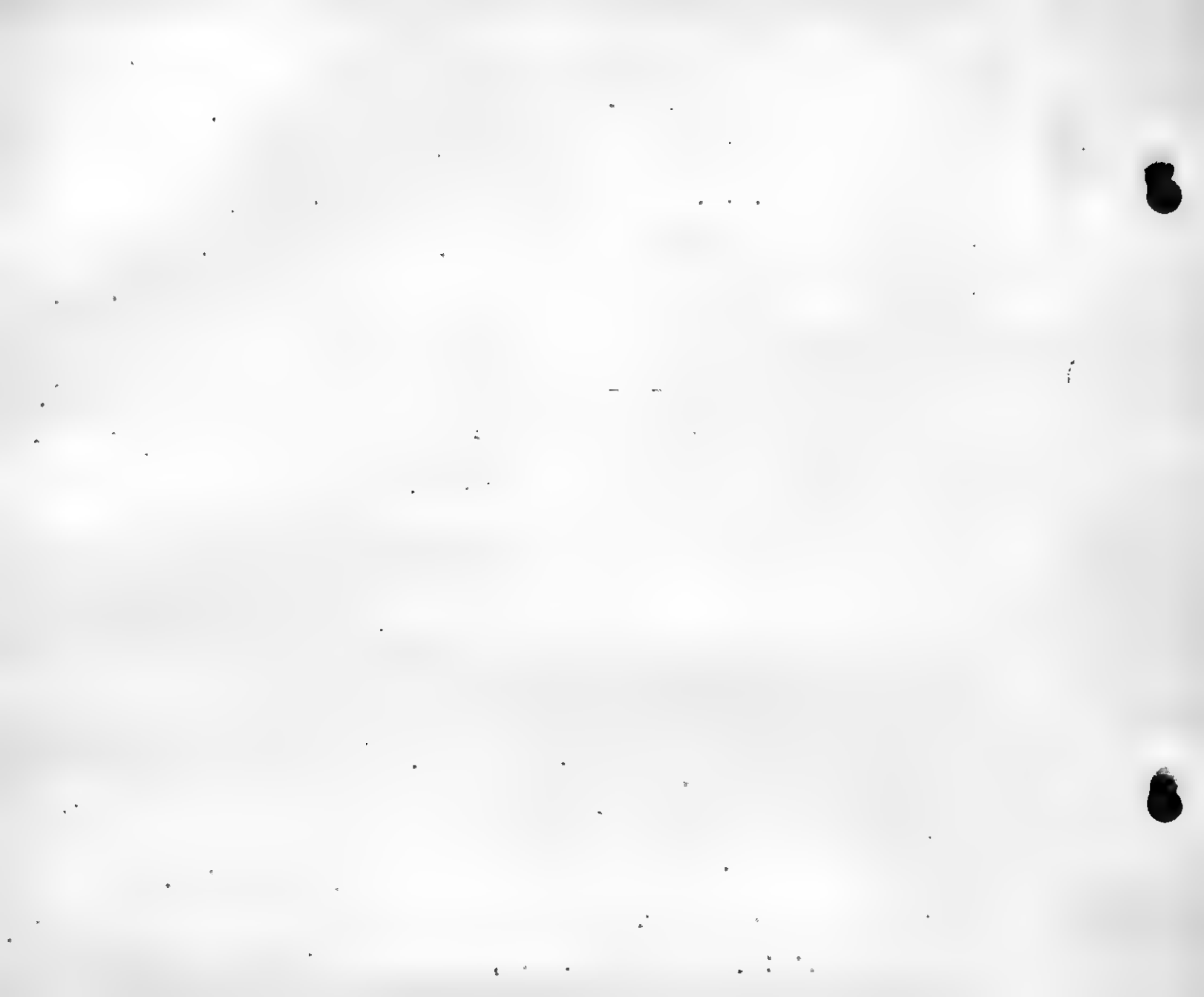
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur al-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (1 and 2) and completely fill in the remaining spaces (3 and 4) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
17893 CERTIFICATE OF DEATH 17904															
1. DECEASED NAME (Type or print)				First Middle Last				20. DATE OF DEATH				2b. HOUR			
Martha Skinner Newell								Month Day Year				7:00A M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.			
female		white		12/8/77				91 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
New York				U.S.A.								Montgomery Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				11725 Kemp Mill Rd.				Writer-magazine							
13a. USUA. RESIDENCE (Where deceased lived, if institut on. Residence before admiss on) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Montgomery				Silver Spring				YES <input type="checkbox"/> NO <input type="checkbox"/>		11725 Kemp Mill Rd.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Lyman Skinner				Helen Gibbs											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address			
				578-34-2206A				Betty Newell				11725 Kemp Mill Rd. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis												5 Days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) Atherosclerosis															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
332x															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 1968, that (I) (we) last saw the deceased alive on 20 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE William D. Aud DEGREE								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/23/68			
22d. PHYSICIAN'S NAME (Type) William D. Aud								22e. ADDRESS 9006 Coleville Rd. Silver Spring Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE 12/26/68				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION (City or Town) Prince Georges County, Md. (County) (State)			
24. FUNERAL DIRECTOR The S.H. Hines Company, D.C.								25a. REC'D BY REGISTRAR DATE DEC 26 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17905

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <b>Albert</b>			First <b>Albert</b>			Middle <b>Newman</b>			Last <b>Newman</b>			2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> <b>12/10</b> 19 <b>68</b>			2b. HOUR <b>10:40</b>								
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9/19/18</b>		6. AGE (n years last birthday) <b>50</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>10</b> Year <b>1968</b>			2d. HOUR <b>10:40</b>								
7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Montgomery</b>											
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Home Improvement Contractor</b>				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Sil. Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Silver Spring, 12605 Atherton Dr. Md.</b>											
14. FATHER'S NAME <b>Jack</b>						First <b>Jack</b>						Middle <b>Newman</b>											
15. MOTHER'S MAIDEN NAME <b>Edna</b>						First <b>Edna</b>						Middle <b>Edna</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				(If yes give year or dates of service)				16b. SOCIAL SECURITY NO. <b>051-10-3781</b>				17. INFORMANT <b>Jan B. Newman</b>				ADDRESS <b>same as 13 above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Coronary Insufficiency</b> <b>Coronary Artery Heart Disease</b>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <b>Belden R. Reap</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED <b>Dec. 10, 1968</b>											
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>						ASSISTANT MED. CAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ADDRESS (Street, City, County, or State)						ADDRESS (Street, City, County, or State)						ADDRESS (Street, City, County, or State)											
23a. BURIAL, CREMATION, or other (Specify) <b>Burial</b>						23b. DATE <b>Dec. 12, 1968</b>						23c. NAME OF CEMETERY OR CREMATORY <b>G. W. Cemetery</b>											
23d. LOCATION (City or Town) <b>Hyattsville, Md.</b>						(County)						(State)											
24. FUNERAL DIRECTOR <b>Charles Judge</b>						ADDRESS <b>4217 P. St. S.W.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 13 1968</b>						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17805

17906

1. DECEASED-NAME (Type or Print) <i>Andrew C. Newman</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>12</i> Day <i>14</i> Year <i>1968</i>			2b. HOUR <i>6:15 AM</i>			
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Oct. 22, 1902</i>	6 AGE (in years last birthday) <i>66</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>12</i> Day <i>14</i> Year <i>1968</i>			2d. HOUR <i>6:15 AM</i>
7a. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3010 Dawson Avenue</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3010 Dawson Avenue</i>		
14. FATHER'S NAME First <i>Alfred R</i> Middle <i>C.</i> Last <i>Newman</i>			15. MOTHER'S MAIDEN NAME First <i>Anne</i> Middle <i>J.</i> Last <i>Roach</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			16b. SOCIAL SECURITY NO <i>526 -03-9816</i>		17. INFORMANT ADDRESS <i>Mrs. Stella L. Newman 3010 Dawson Avenue S.S.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1731 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1992</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A M P M <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>December 15, 1968</i>			
EXAMINER'S NAME (Type) <i>Belden R. Reap M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			23b. DATE <i>12-16-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince George's Maryland</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i>			25a. ADDRESS <i>8434 Ga. Ave. S.S., Md.</i>			25b. REC'D BY REG. STRAR DATE <i>DEC 19 1968</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

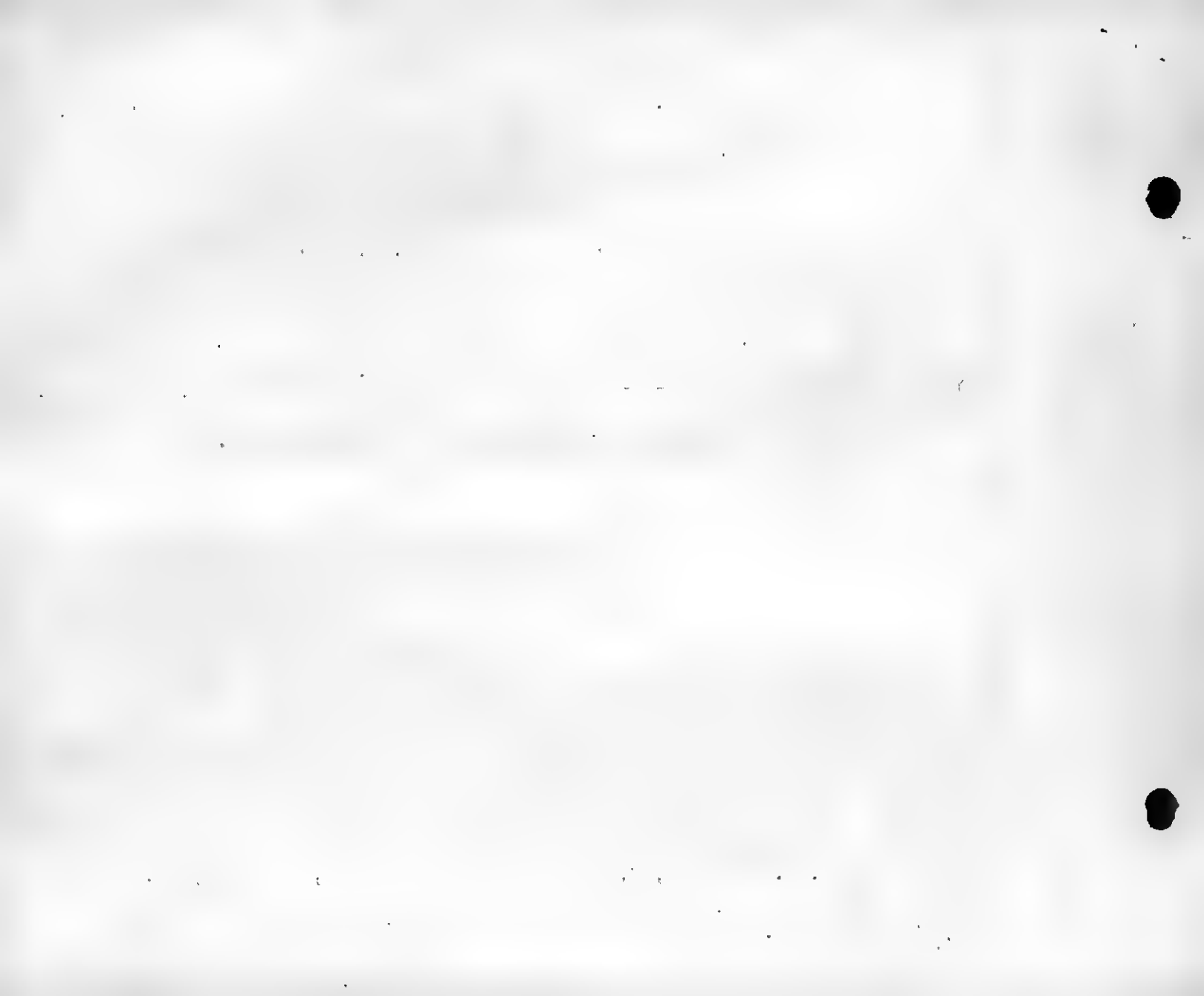
17896

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17907

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>ANDREW M. NEWMAN</b>			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>12</b> Year <b>1968</b>		2b. HOUR <b>9:55P</b> M
3. SEX <b>MALE</b>	4 RACE <b>CAUCASIAN</b>	5 DATE OF BIRTH <b>MAY 12, 1899</b>		6 AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>BETHESDA, MARYLAND</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>U. S. NAVY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MILITARY</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>	13b. CITY OR TOWN <b>CHARLES TOMPKINSVILLE</b>	13c. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14 FATHER'S NAME First <b>JOHN</b> Middle <b>F.</b> Last <b>NEWMAN</b>	15 MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>M.</b> Last <b>(UNKNOWN)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) <b>YES WWI, WWII</b>	16b. SOCIAL SECURITY NO. <b>213-44-6013A</b>	(SURNAMANT) <b>WILLIAM A. NEWMAN</b> Address <b>4502 EAST-WEST HIGHWAY, BETHESDA, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT MELANOMA WITH MULTIPLE METASTASIS</b> <b>1721</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 25, 1968</b> , to <b>DEC 12, 1968</b> , that <b>XX</b> (we) last saw the deceased alive on <b>DEC 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>XI</b> (we) (did) ( <del>did not</del> ) view the body after death.					
22b. SIGNATURE <b>P. J. Dean</b> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>13 DEC 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>P. J. DEAN CDR, MC, USN</b>				22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-16-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>PUMPHREY FUNERAL HOME</b> <b>7557 WISCONSIN AVE., BETHESDA, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>DEC 18 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**FOR STATE  
HEALTH. DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

17807

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17908

1 DECEASED NAME (Type or Print) <b>Rudolph Jackson Nichols</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Dec</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>10:40 AM</b>		
3 SEX <b>M</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH <b>Feb 10, 1913</b>	6 AGE (in years last birthday) <b>55</b> YRS	IF UNDER 24 HRS. MONTHS <b>10</b> DAYS <b>19</b>	IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD Month <b>Dec</b> Day <b>29</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Suburban</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9400 Rockville Pike</b>
14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b></b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Acker</b> Last <b></b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes.</b> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO <b>unknown</b>			17. INFORMANT <b>(Brother) Robert Griffin Severin, MD</b>			ADDRESS <b>1410 Cypress Rd</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction - Acute -</b>							<b>Hours.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardio-vascular Disease -</b>							<b>years.</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>7201</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b></b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John G. Ball</b>		EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Dec 29, 1968</b>		
ADDRESS (Street, city, town, or county) <b>Bethesda, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-31-68</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Williams Cemetery.</b>		23d. LOCATION (City or Town) (County) (State) <b>Shelby County, Ala.</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>				25a. REC'D BY REG STRAR DATE <b>JAN 9 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The following requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transmittal permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR  
45M

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17898

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17909

1 DECEASED-NAME (Type or print) <u>May Eve Nicholson</u>			2a. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>68</u>			2b. HOUR <u>3:50 PM</u>				
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>June 16, 1888</u>		6 AGE (in years last birthday) <u>80 YRS</u>		7c UNDER 24 HRS MONTHS <u>00</u> DAYS <u>00</u> HOURS <u>00</u> MIN <u>00</u>		
7a BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>			Md	
10 CITY OR TOWN OF DEATH <u>Rockville</u>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <u>Potomac Valley Nursing Home</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY				
13a U.S.A. RESIDENCE (Where deceased admission) <u>Maryland</u>		13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Gaithersburg</u>		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>202 N. Frederick Ave.</u>		
4 FATHER'S NAME First <u>Charles W.</u> Middle <u>Ward</u> Last <u>Ward</u>			15 MOTHER'S MAIDEN NAME First <u>Hattie L.</u> Middle <u>Duvall</u> Last <u>Duvall</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		16b SOC AL SECURITY NO (If yes give war or dates of service)		17 INFORMANT Address <u>J. Arthur Nicholson, Gaithersburg, Md.</u>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intra Cranial Hemorrhage 3 days</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebro. Arteriosclerosis Years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis Years</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>331X</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1949</u> , to <u>Dec 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 6 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <u>3:50 pm</u>										
22b. SIGNATURE <u>Jack Schumacher</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>12-6-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M.D.</u>		22e. ADDRESS <u>Gaithersburg, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 9, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem Meth.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cedar Grove, Md.</u>				
24. FUNERAL DIRECTOR <u>Orin L. Molesworth,</u>		ADDRESS <u>Damascus, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Part 1, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>FERMOND A NORRIS</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> <i>Dec. 8 1968</i>		2b. HOUR <i>9:50 PM</i>			
3 SEX <i>M.</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH <i>Sept 8 1904</i>	6 AGE (in years last birthday) <i>64 YRS</i>	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>Dec</i> Day <i>8</i> Year <i>1968</i>		2d. HOUR <i>10:15 PM</i>			
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Bethesda.</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>705 Beall Ave.</i>	
14 FATHER'S NAME First <i>Henry</i> Middle <i>Norris</i> Last <i>Norris</i>				15. MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>Anders</i> Last <i>Anders</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>yes unknown</i>		17 INFORMANT <i>Minnie Brandau</i>		ADDRESS <i>5701 Wyngate Dr. Bethesda, Md</i>				
18 CAUSE OF DEATH (Enter only one cause per Part 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchial Asthma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>241x</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>12/19/68</i>	
				ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville, Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville Mont. Md</i>		(County)		(State)	
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>				ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>				25a. RECD BY REGISTRAR <i>DEC 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
HARRY BERNARD O'DELL						December 19, 1968			M
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR	
Male		White		July 24, 1903		65 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Virginia		USA				Montgomery Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		Cab Driver Ret.		Diamond Cab Co.			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				4525 Randolph Road	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
Yes		1920-1921 578-28-5720		Mrs Bark O. O'Dell		4525 Randolph Rd. Silver Spring Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Heart Failure									2 years
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Arteriosclerotic Heart Disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4?									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to 12-18, 1968, that (I) (we) last saw the deceased alive on 12-17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
L. I. LEAL, M.D.						12/19/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
L. I. LEAL, M.D.		Medical Center		108 N. Federal Street, Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		Dec 21, 1968		Blandford Cemetery		Petersburg, Virginia			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. W. CHAMBERS CO.		8655 Georgia Ave Silver Spring, Md.		DEC 23 1968		notarized Judge			

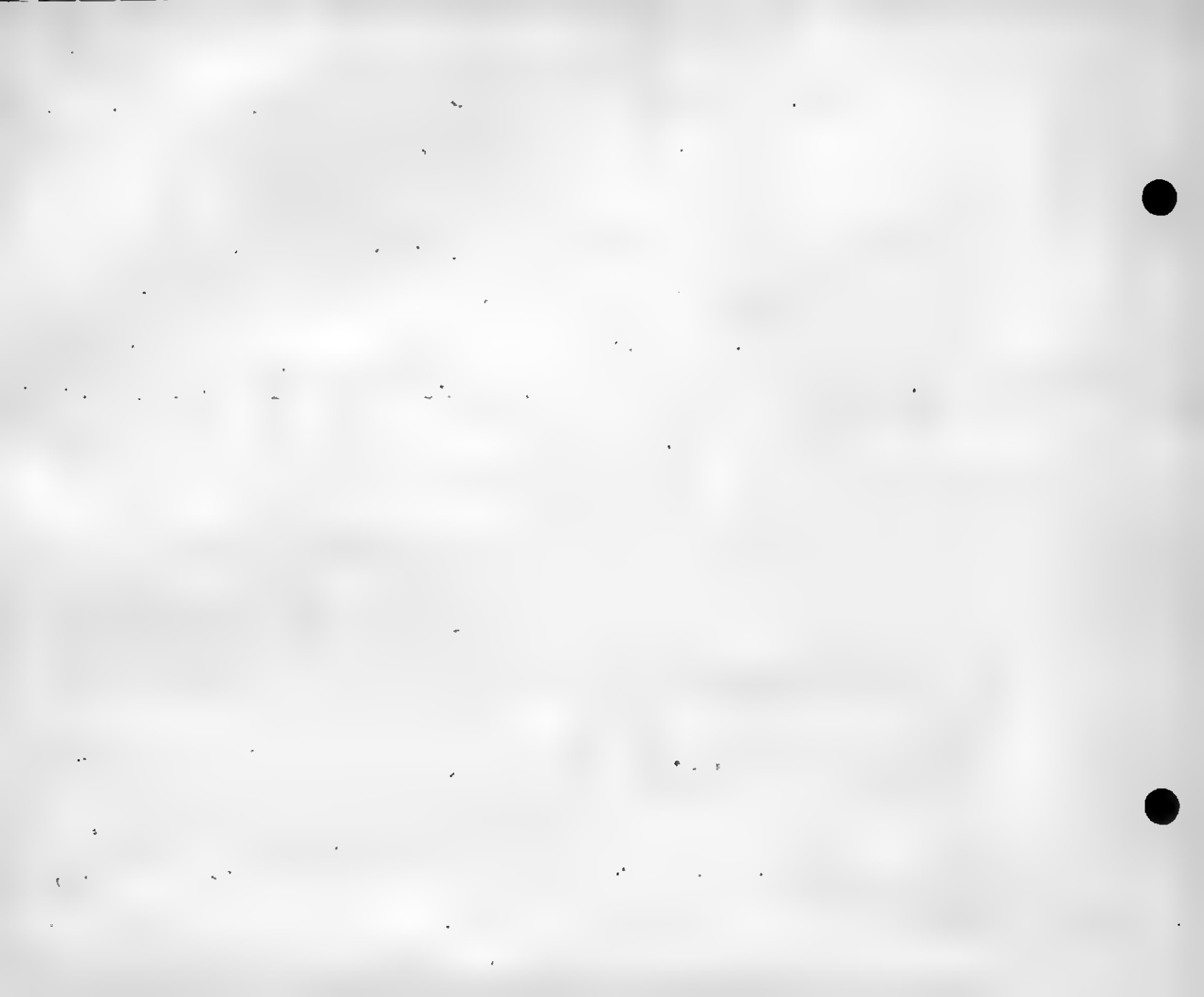
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|---|--|
| 17991   |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  | 17912   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Anthony Paul Oliveri</b>  |  |  |  |  | 2a. DATE OF DEATH<br>Month <b>December</b> Day <b>6</b> Year <b>1968</b>                |  |  |  |  | 2b. HOUR A<br><b>7:30 M</b>   |  |  |  |   |  |
| 3 SEX<br><b>Male</b>  |  |  | 4 RACE<br><b>White</b>   |  |   | 5. DATE OF BIRTH<br><b>18 September 1946</b>   |  |  | 6. AGE (In years last birthday)<br><b>22</b> YRS.                                  |   |  | IF UNDER 1 YEAR<br>MONTHS <b>2</b> DAYS <b>2</b> |  | IF UNDER 24 HRS.<br>HOURS <b>2</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington, DC</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md   |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>The Clinical Center</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Apprentice Electrician</b>                                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>STATE <b>Maryland</b> CITY <b>Prince Georges</b>   |  |  | 13c. CITY OR TOWN<br><b>Seabrook</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e. STREET AND NUMBER<br><b>9805 Telegraph Road, Apt 12</b>                       |   |  |  |  |   |  |
| 14. FATHER'S NAME First <b>Anthony</b> Middle <b>S.</b> Last <b>Oliveri</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Laura</b> Middle <b>Swetland</b> Last <b>Swetland</b> |  |  |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO<br><b>1966-1967 579-62-1018</b>  |  |   | 17 INFORMANT <b>The Medical Records</b> Address<br><b>The Clinical Center, NIH, Bethesda, Md. 20014</b>  |  |  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Hepatic Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hodgkin's Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>1 year</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |   |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>7 Nov.</b> , 19 <b>68</b> , to <b>6 Dec.</b> , 19 <b>68</b> , that <del>he</del> (we) lost saw the deceased alive on <b>6 December</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>(do not)</del> view the body after death. |  |  |  |  |   |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Pete J. Rosen M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |   |  |  | 22c. DATE SIGNED<br><b>6 December 1968</b>   |  |   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Peter J. Rosen, M.D.</b>   |  |  |  |  |   |  |  | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b> |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Dec 9, 1968</b>  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>   |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons   |  |  |  |  |   | ADDRESS<br><b>Hyattsville, Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 9 1968</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove corpse to the funeral home. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17992  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 17913   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-----------------|--|--|--|--|---------------------------|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 1 DECEASED-NAME<br>(Type or print)   |  |  |  |  | First<br><i>Lena</i>   |  |  |  |  | Middle<br><i>M.</i>   |  |  |  |  | Last<br><i>Oram</i>   |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  | 2b. HOUR        |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  | Month<br><i>12</i>  |  |  |  |  | Day<br><i>7</i> |  |  |  |  | Year<br><i>68</i>         |  |  |  |  | 7 <sup>29</sup> A M |  |  |  |  |  |  |  |  |  |
| 3 SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5 DATE OF BIRTH   |  |  |  |  | 6 AGE (In years last birthday)  |  |  |  |  | IF UNDER 1 YEAR   |  |  |  |  | IF UNDER 24 HRS |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Female</i>  |  |  |  |  | <i>White</i>   |  |  |  |  | <i>3-1-1901</i>   |  |  |  |  | <i>67</i> YRS.  |  |  |  |  | MONTHS  |  |  |  |  | DAYS            |  |  |  |  | HOURS                     |  |  |  |  | MIN                 |  |  |  |  |  |  |  |  |  |
| 7a BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b CITIZEN OF WHAT COUNTRY?  |  |  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Pennsylvania</i>  |  |  |  |  | <i>U.S.A.</i>  |  |  |  |  |   |  |  |  |  | <i>Montgomery</i>   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |  |  |  |  | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)  |  |  |  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Rockville</i>   |  |  |  |  | <i>Patoma Valley Hosp. Home</i>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  |  |  |  |  | 13b COUNTY   |  |  |  |  | 13c CITY OR TOWN  |  |  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e STREET AND NUMBER   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>md.</i>   |  |  |  |  | <i>Montgomery</i>  |  |  |  |  | <i>Rockville</i>  |  |  |  |  |   |  |  |  |  | <i>306 Reading Ave.</i>   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME   |  |  |  |  | First  |  |  |  |  | Middle  |  |  |  |  | Last  |  |  |  |  | 15 MOTHER'S MAIDEN NAME   |  |  |  |  | First           |  |  |  |  | Middle                    |  |  |  |  | Last                |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  | 16b SOCIAL SECURITY NO   |  |  |  |  | 17 INFORMANT  |  |  |  |  | Address   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | <i>Best Home Records</i>  |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| PART 1 DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | <i>1 hr</i>   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| (b) <i>Coronary Thrombosis</i>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | <i>1 hr.</i>  |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| (c) <i>Coronary Arteriosclerosis</i>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | <i>10 yrs</i>   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Arterio Sclerotic</i>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |  |  | 20a AUTOPSY?  |  |  |  |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING  |  |  |  |  | 21b TIME OF INJURY   |  |  |  |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| (If either, notify medical examiner)   |  |  |  |  | P.M. 19  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f LOCATION  |  |  |  |  | Street or R.F.D. No.  |  |  |  |  | City or Town  |  |  |  |  | County          |  |  |  |  | State                     |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| of work <input type="checkbox"/> of work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/27/68</i> , 19 <i>68</i> , to <i>12/7/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/6/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE  |  |  |  |  |  |  |  |  |  | DEGREE  |  |  |  |  |   |  |  |  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  |  |  |  |                 |  |  |  |  | 22c. DATE SIGNED          |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Stephen H. Jones</i>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  | <i>12/7/68</i>            |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 22d PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e ADDRESS   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Stephen H. Jones, M.D.</i>  |  |  |  |  |  |  |  |  |  | <i>Rockville, Md.</i>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                 |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d LOCATION (City or Town)   |  |  |  |  | (County)  |  |  |  |  | (State)         |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Burial</i>  |  |  |  |  | <i>12/10/68</i>  |  |  |  |  | <i>Parklawn Cemetery</i>  |  |  |  |  | <i>Rockville</i>  |  |  |  |  |   |  |  |  |  | <i>Maryland</i> |  |  |  |  |                           |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |   |  |  |  |  | 25a REC'D BY REGISTRAR  |  |  |  |  |                 |  |  |  |  | 25b REGISTRAR'S SIGNATURE |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |
| <i>Tyson Wheeler Funeral Home</i>  |  |  |  |  |  |  |  |  |  | <i>Rockville, Md.</i>   |  |  |  |  |   |  |  |  |  | <i>DEC 9 1968</i>   |  |  |  |  |                 |  |  |  |  | <i>Charles Judge</i>      |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |





FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages, and with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17993 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17914

|   |           |                             |   |   |  |   |  |   |  |
|---|-----------|-----------------------------|---|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(Type or Print)  |           |                             | First   | Middle  | Last   | 2a DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 12-6-1968     |  |   | 2b HOUR<br>5:30 AM                           |
| Grace Elizabeth Overstreet  |           |                             |   |   |  |   |  |   |  |
| 3 SEX   | 4 RACE    | 5 DATE OF BIRTH             | 6 AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN  |  | 2c DATE PRONOUNCED DEAD<br>Month 12 Day 6 Year 1968 | 2d HOUR<br>5:30 AM                           |
| Female  | Caucasian | 5-5-1888                    | 80 YRS  |   |  |   |  |   |  |
| 7a BIRTHPLACE (State or foreign country)  |           | 7b CITIZEN OF WHAT COUNTRY? |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   | Md   |
| New York  |           | United States               |   |   |  | Montgomery  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |           |                             | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b KIND OF BUSINESS OR INDUSTRY                    |  |
| Olney   |           |                             | Brooke Grove Foundation   |   |  |   |  |   |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE  |           |                             | 13b COUNTY  |   | 13c CITY OR TOWN   |   | 13e STREET AND NUMBER                        |   |  |
| Maryland  |           |                             | Montgomery  |   | Silver Spring  |   | 3916 Linden Road, Silver                     |   |  |
| 14. FATHER'S NAME   |           |                             | 15 MOTHER'S MAIDEN NAME   |   |  |   |  |   |  |
| First Middle Last   |           |                             | First Middle Last   |   |  |   |  |   |  |
| Oliver Mann   |           |                             | Inez Carroll  |   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |           |                             | 16b SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   |  |   |  |
| no  |           |                             | 577-40-0039   |   | Mr. Charles Brown, 3916 Linden Road, Silver                                      |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |           |                             |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>   |           |                             |   |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>  |           |                             |   |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |           |                             |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |           |                             |   |   |  |   |  |   |  |
| +201  |           |                             |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |           |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |   |  | 20 AUTOPSY?   |  |   |  |
|   |           |                             |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |   |  |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |           |                             | 21b TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                       |   | 21c HOW INJURY OCCURRED (Enter nature of injury, if Row 1 or Part 2, then Row 2) |   |  |   |  |
|   |           |                             | 11-3 1968   |   | Deceased fell out of wheel chair at Nursing Home 7x left                         |   |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |           |                             | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f LOCATION Street or R.F.D. No. City or Town County                            |   |  |   |  |
|   |           |                             | Home  |   | Silver Spring, Montgom. Md.  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |           |                             |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE  |           |                             | CHIEF MEDICAL EXAMINER  |   |  | 22b DATE SIGNED   |  |   |  |
| EXAMINER'S NAME (Type)  |           |                             | M.D.  |   |  | 1968  |  |   |  |
| Belden R. Reap, M.D.  |           |                             | Wheaton, Mont. Co., Md.   |   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |           |                             | 23b DATE  |   | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION (City or Town) (County) (State) |   |  |
| Cremation   |           |                             | 12-9-1968   |   | Cedar Hill Crematory   |   | Suitland, Prince Georges Co. Md.             |   |  |
| 24 FUNERAL DIRECTOR   |           |                             | 25a REC'D BY REGISTRAR  |   |  | 25b REGISTRAR'S SIGNATURE   |  |   |  |
| JOSEPH GAWLER'S SONS  |           |                             | 5130 Wisconsin Ave., N.W. Washington, D. C.                                 |   |  | DEC 12 1968 Charles Judge   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove accession papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
|---|--|---------|------------------------------|--|--|--|---------------------------------|---|-----------------------|--|------------------|--|----------------|--|--|
| CERTIFICATE OF DEATH  |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| 1. DECEASED-NAME (Type or print)  |  |         | First Middle Last            |  |  | 2a. DATE OF DEATH  |                                 |   | 2b. HOUR              |  |                  |  |                |  |  |
| Mose  |  |         | T. Paden                     |  |  | Month Day Year   |                                 |   | 17 1968 34            |  |                  |  |                |  |  |
| 3 SEX   |  | 4. RACE |                              | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday) |   | 7. UNDER 1 YEAR       |  | 8. UNDER 24 HRS. |  |                |  |  |
| male  |  | white   |                              | 10-12-03   |  |  | 62                              |   | MONTHS DAYS HOURS MIN |  |                  |  |                |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |   | 9. COUNTY OF DEATH    |  |                  |  |                |  |  |
| West. Va.   |  |         | U.S.A.                       |  |  |  |                                 |   | Montgomery            |  |                  | Md   |                |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                       |  |                  | 12b. KIND OF BUSINESS OR INDUSTRY  |                |  |  |
| Bethesda  |  |         |                              | Suburban   |  |  |                                 | Salesman  |                       |  |                  | Auto   |                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  |  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |                       | 13e. STREET AND NUMBER   |                  |  | 13f. APPT. NO. |  |  |
| Md.   |  |         |                              | Montgomery   |  | Cherry Chase   |                                 |   |                       | 4740 - Bradley Blvd  |                  |  | 1701-224       |  |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME     |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| First Middle Last   |  |         | First Middle Last            |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| Louis   |  |         | Paden                        |  |  | Anna   |                                 |   | Caplan                |  |                  |  |                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |         |                              | 16b. SOCIAL SECURITY NO  |  |  |                                 | 17. INFORMANT   |                       |  |                  | Address  |                |  |  |
| NO  |  |         |                              | 236-05-8451  |  |  |                                 | Bessie Paden  |                       |  |                  | Same As Above  |                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |                              |  |  |  |                                 |   |                       |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                |  |  |
| PART I DEATH WAS CAUSED BY:   |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| IMMEDIATE CAUSE (a) Pulmonary Edema   |  |         |                              |  |  |  |                                 |   |                       |  |                  | 36 hours   |                |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| (b) Myocardial Infarction   |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| (c) Atherosclerotic Coronary Heart Disease  |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| 4201  |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| 19a. DATE OF OPERATION  |  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                                 | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |                       |  |                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)          |                       |  |                  |  |                |  |  |
| 21a. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |         |                              | 21b. PLACE OF INJURY (At home farm, street, factory, office building, etc.)  |  |  |                                 | 21c. LOCATION Street or R.F.D. No City or Town County State                             |                       |  |                  |  |                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 4, 1968, to Dec 17, 1968, that (I) (we) last saw the deceased alive on Dec 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |                              |  |  |  |                                 |   |                       |  |                  |  |                |  |  |
| 22b. SIGNATURE  |  |         |                              |  |  |  |                                 | DEGREE  |                       | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |                  | 22c. DATE SIGNED   |                |  |  |
| P.P. Andrews M.D.   |  |         |                              |  |  |  |                                 |   |                       |  |                  | 12-17-68   |                |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |         |                              |  |  |  |                                 | 22e. ADDRESS  |                       |  |                  |  |                |  |  |
| P.P. ANDREWS M.D.   |  |         |                              |  |  |  |                                 | Washington D.C. 20016   |                       |  |                  |  |                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                 |   |                       | 23d. LOCATION (City or Town) (County) (State)  |                  |  |                |  |  |
| BURIAL  |  |         |                              | 12-19-1968   |  | DRAINACOB CEM  |                                 |   |                       | CHARLESTON W. VA   |                  |  |                |  |  |
| 24. FUNERAL DIRECTOR  |  |         |                              |  |  |  |                                 | ADDRESS   |                       | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE   |                |  |  |
| GOLDEN FUNERAL HOME   |  |         |                              |  |  |  |                                 | 4217 9th St N.W.  |                       | DEC 23 1968  |                  |  |                |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17995

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17916

|  |        |                              |  |  |  |   |  |                          |   |  |          |
|--|--------|------------------------------|--|--|--|---|--|--------------------------|---|--|----------|
| 1. DECEASED NAME<br>(Type or Print)  |        |                              | First Middle Last  |  |  | 2a. DATE KNOWN OF DEATH   |  |                          | 2b. HOUR  |  |          |
| William T. Payne   |        |                              |  |  |  | DATE OF EST. <input checked="" type="checkbox"/> MONTH DAY YEAR                         |  |                          | 12-31 1968 11:15 AM   |  |          |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH              | 6 AGE (In years last birthday)   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |
| M  | W      | 3/29/48                      | 20 YRS   | MONTHS DAYS  |  | HOURS MIN.  |  | 12 31 Year 68            |   |  | 11:15 AM |
| 7a. BIRTHPLACE (State or foreign country)  |        | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                          | Md  |  |          |
| Wash. DC   |        | U.S.A.                       |  |  |  | Montgomery  |  |                          |   |  |          |
| 10. CITY OR TOWN OF DEATH  |        |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |
| Silver Spring  |        |                              | Holy Cross Hosp.   |  |  | STUDENT   |  |                          |   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE   |        |                              | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |                          | 13d. INSIDE CITY LIMITS?  |  |          |
| Md.  |        |                              | Montgomery   |  |  | Rockville   |  |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 14. FATHER'S NAME  |        |                              | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |                          | 16b. SOCIAL SECURITY NO   |  |          |
| GEORGE F. PAYNE  |        |                              | EDYTHE Y. JOHNSON  |  |  | NO  |  |                          | 173-38-9395   |  |          |
| 17. INFORMANT  |        |                              | ADDRESS  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))                 |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |          |
| Mrs. Edythe Y. Payne, Mother, Same as #13  |        |                              |  |  |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Extreme Injuries              |  |                          |   |  |          |
|  |        |                              |  |  |  | (b) with Skull Fracture and   |  |                          |   |  |          |
|  |        |                              |  |  |  | (c) Internal Hemorrhage   |  |                          |   |  |          |
| 19a. DATE OF OPERATION   |        |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  | 20. AUTOPSY?  |  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        |                              | 21b. TIME OF INJURY Month, Day, Year   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)          |  |                          |   |  |          |
| 230 PM 12-31 1968  |        |                              | Deceased, driven through car   |  |  | which struck bridge support   |  |                          |   |  |          |
| 21d. INJURY OCCURRED   |        |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)  |  |  | 21f. LOCATION (Street or R.F.D. No. City or town County State)                          |  |                          |   |  |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |        |                              | Street 495   |  |  | Silver Spring Beltway 495 Montgomery Md.  |  |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from |        |                              | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | 22b. DATE SIGNED  |  |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from |        |                              | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | 22b. DATE SIGNED  |  |                          |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |        |                              | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          | 23d. LOCATION (City or Town) (County) (State)                       |  |          |
| Cremation  |        |                              | 1/2/69   |  |  | Cedar Hill Crematory  |  |                          | Suitland, Maryland  |  |          |
| 24. FUNERAL DIRECTOR   |        |                              | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR   |  |                          | 25b. REGISTRAR'S SIGNATURE  |  |          |
| Joseph Gawler's Sons, Inc., Washington, D. C.  |        |                              |  |  |  | JAN 8 1969  |  |                          | [Signature]   |  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17998

17917

|   |  |   |   |  |  |  |   |
|---|--|---|---|--|--|--|---|
| 1 DECEASED-NAME<br>(Type or print) <b>First</b> <i>AGNES</i> <b>Middle</b> <i>PELZER</i> <b>Last</b>  |  |   | 2a. DATE OF DEATH<br>Month <i>11</i> Day <i>18</i> Year <i>1968</i> |  |  | 2b. HOUR<br><i>30</i> M  |   |
| 3 SEX <i>F.</i>   |  | 4 RACE <i>White</i>   |   | 5. DATE OF BIRTH<br><i>Sept 22, 1883</i>   |  | 6 AGE (in years<br>last birthday) <i>85</i> YRS  |   |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>MEADIA, GERMANY</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><i>Montgomery</i> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville</i>   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>Potomac Valley Nursing Home</i> |   | 12a. USUA. OCCUPATION (Kind of work done<br>during most of working life even if retired) <i>HOUSEWIFE</i>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) <i>Md.</i>   |  | 13b. COUNTY <i>Montg.</i>   |   | 13c. CITY OR TOWN <i>Bethesda</i>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 13e. STREET AND NUMBER<br><i>6620 Rannock Rd.</i>   |  | 14. FATHER'S NAME <b>First</b> <i>Peter</i> <b>Middle</b> <i>Rudolf</i> <b>Last</b>                               |   | 15 MOTHER'S MAIDEN NAME <b>First</b> <i>Jane</i> <b>Middle</b> <i>Joong</i> <b>Last</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO<br><i>241-385832</i>  |   | 17 INFORMANT <i>Z F. Neves</i>   |  | Address <i>6620 Rannock Rd. Bethesda Md.</i>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebrovascular Thrombosis</i>   |  |   |   |  |  |  | <i>8 MRS.</i>                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>   |  |   |   |  |  |  | <i>5 YRS.</i>                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Chronic urinary tract infection</i>   |  |   |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                      |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><i>19</i>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)  |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY)<br>OFFICE BUILDING, ETC  |   | 21f. LOCATION Street or R.F.D. No City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 67</i> , 19 <i>67</i> to <i>12/10/68</i> , that (I) (we) last<br>saw the deceased alive on <i>12/10/68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |   |
| 22b. SIGNATURE<br><i>Henry C. Scruggs</i>   |  |   |   | 22c. DATE SIGNED<br><i>12/11/68</i>  |  |  |   |
| 22d. PHYSICIAN'S<br>NAME (Type) <i>Henry C. Scruggs, M. D.</i>  |  |   |   | 22e. ADDRESS<br><i>5413 Cedar La., Bethesda, Md.</i>   |  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL, SPOULDER  |  | 23b. DATE<br><i>12-13-68</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ethworth M.E. Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Rehobeth Beach Del.</i>                  |   |
| 24. FUNERAL DIRECTOR<br><i>Robert A. Pumphrey</i>   |  |   |   | 25a. REC'D BY REGISTRAR<br><i>7557 Wisconsin Ave<br/>Bethesda, Md.</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   |

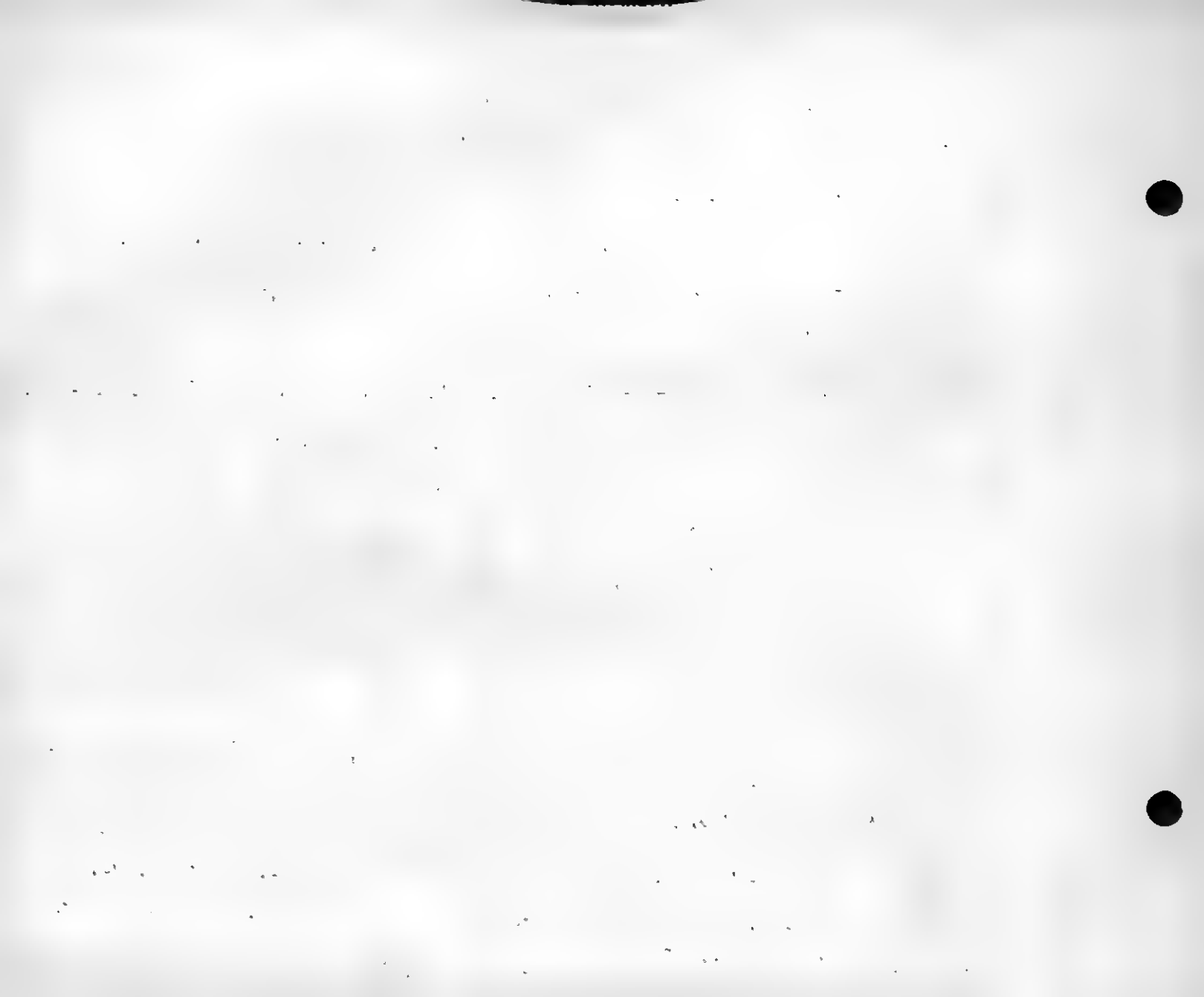




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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
|--|--|---------|---|---|--|---|--|---|--|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
| 1 DECEASED-NAME (Type or print)  |  |         | First Middle Last   |   |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR   |  |  |                                   |  |
| William E. Peters  |  |         |   |   |  | Month Day Year  |  |   | 10:10 P M  |  |  |                                   |  |
| 3 SEX  |  | 4. RACE |   | 5. DATE OF BIRTH  |  | 6 AGE (in years last birthday)  |  | 7 UNDER 1 YEAR  |  | IF UNDER 24 HRS                              |  |                                   |  |
| MALE   |  | WHITE   |   | 12/11/10  |  | 58 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.                                   |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?  |   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9 COUNTY OF DEATH  |  |  |                                   |  |
| Virginia   |  |         | U.S. A.   |   |  |   |  |   | Montgomery Md.   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |         |   | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Silver Spring  |  |         |   | Holy Cross  |  |   |  | Electrician   |  |  |  | Self-employed                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE  |  |         |   | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                       |  |                                   |  |
| Maryland   |  |         |   | Montgomery  |  | Silver Spring   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 10406 Graden Road                            |  |                                   |  |
| 14 FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME  |   |  |   |  |   |  |  |  |                                   |  |
| First Middle Last  |  |         | First Middle Last   |   |  |   |  |   |  |  |  |                                   |  |
| Unknown  |  |         | Unknown   |   |  |   |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |         | 16b. SOCIAL SECURITY NO   |   |  | 17. INFORMANT Address   |  |   |  |  |  |                                   |  |
| No   |  |         | 578-03-7708   |   |  | Mrs. Helen Peters 10406 Graden Rd. S.S. Md.   |  |   |  |  |  |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |   |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                   |  |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest   |  |         |   |   |  |   |  |   |  | sudden                                       |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF Cerebral Embolism, lt   |  |         |   |   |  |   |  |   |  | 3 days.                                      |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF Hypertension Arteriosclerosis, generalized  |  |         |   |   |  |   |  |   |  | 10 yrs.                                      |  |                                   |  |
| (c) Myocardial infarction, Hypertension, lt kidney   |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
| Myocardial infarction, Hypertension, lt kidney   |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY?   |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                                   |  |
|  |  |         |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   | yes  |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |   |  |  |  |                                   |  |
|  |  |         | HOUR A.M. Month Day Year P.M. 19  |   |  |   |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |   |  | 21f. LOCATION   |  |   | City or Town County State  |  |  |                                   |  |
|  |  |         |   |   |  | Street or R.F.D. No   |  |   |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1960, to Dec. 31, 1968, that (I) (we) last saw the deceased alive on Dec. 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |   |   |  |   |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE   |  |         |   |   |  | 22c. DATE SIGNED  |  |   |  |  |  |                                   |  |
| Philip H. Varner, M.D.   |  |         |   |   |  | 1-1-69  |  |   |  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |         |   |   |  | 22e. ADDRESS  |  |   |  |  |  |                                   |  |
| Philip H. Varner, MD   |  |         |   |   |  | 10620 Georgia Ave., Wheaton, Md.  |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State)                        |  |  |                                   |  |
| Burial   |  |         | Jan. 4, 1969  |   |  | Parklawn Cemetery   |  |   | Rockville Montg. Md.   |  |  |                                   |  |
| 24. FUNERAL DIRECTOR   |  |         |   |   |  | 25a. REC'D BY REGISTRAR   |  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |                                   |  |
| Warner E. Pumphrey, Inc., C. G. Carter   |  |         |   |   |  | 8434 Ga., Ave., S.S. Md.  |  |   | JAN 6 1969 J. Charles Judge  |  |  |                                   |  |



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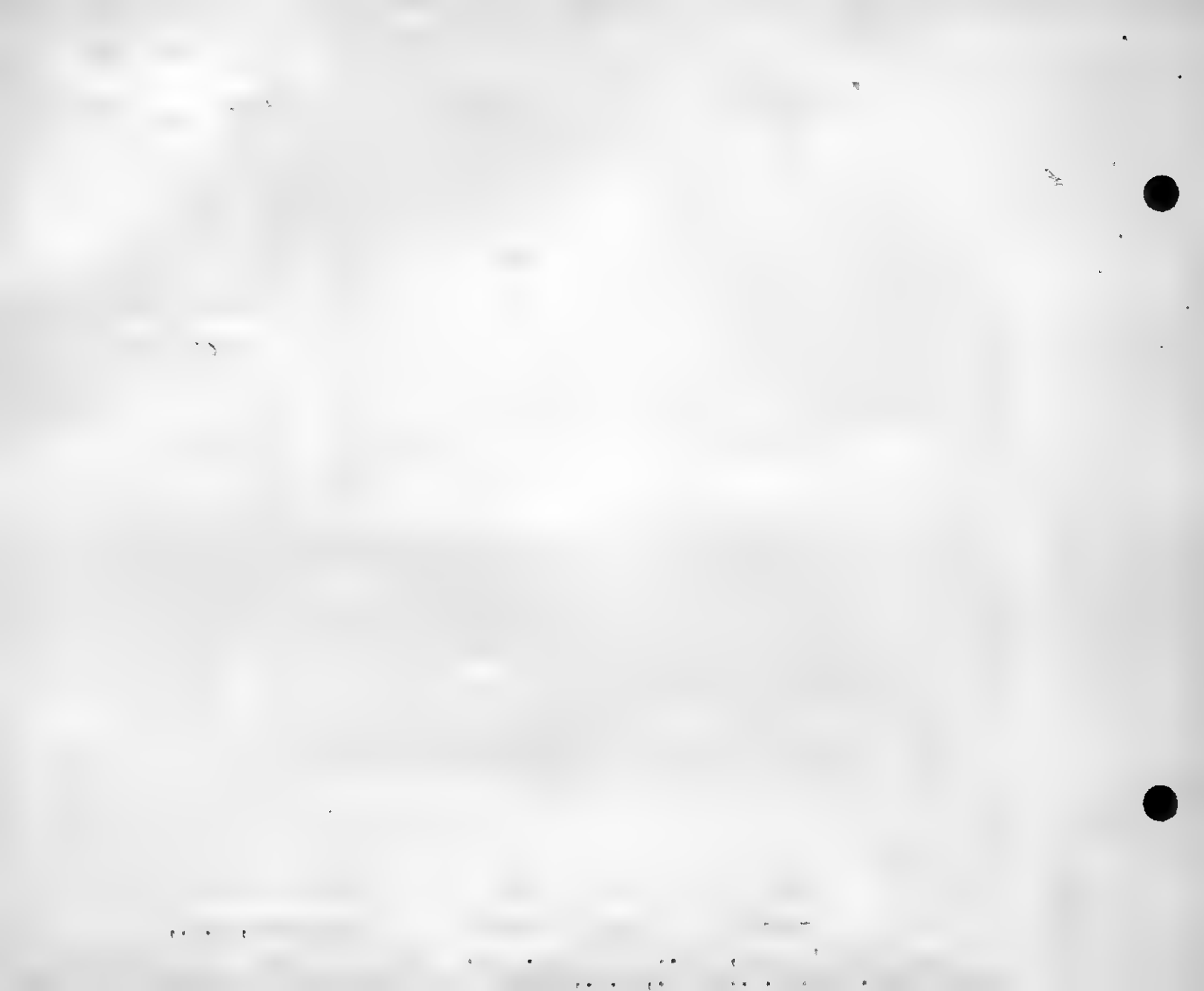
VR A15 (4)  
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120

## CERTIFICATE OF DEATH

17919

|   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (Type or print)<br><b>Edna C. Phelps</b>  |  | First<br><b>C.</b>   |  | Middle<br><b>PHELPS</b>  |  | Last<br><b>PHelps</b>  |  | 2a. DATE OF DEATH<br>Month <b>12</b> Day <b>18</b> Year <b>1968</b>      |  | 2b. HOUR<br><b>12</b>                          |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>W.</b>  |  | 5 DATE OF BIRTH<br><b>6-19-87</b>  |  | 6 AGE (In years last birthday)<br><b>81</b> YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS <b>8</b> DAYS <b>1</b>                          |  | 8 UNDER 24 HRS.<br>HOURS <b>1</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Kensington</b>   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Kensington Gardens San</b> |  | 12a. USUAL OCCUPATION and of work done during most of working life even if retired)<br><b>at home</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><b>Kennedy Warren Apt.</b>  |  | 13b. COUNTY<br><b>Wash. DC</b>   |  | 13c. CITY OR TOWN<br><b>DC</b>   |  | 13d. INS. OF CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3133 Conn. Ave. N.W. DC</b>                 |  |  |  |
| 14. FATHER'S NAME First<br><b>Edward C.</b>   |  | Middle<br><b>Schuyler</b>  |  | Last<br><b>Schuyler</b>  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Elizabeth</b>   |  | Middle<br><b>STASSMAN</b>  |  | Last<br><b>STASSMAN</b>                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO<br><b>577-26-9588</b>  |  | 17 INFORMANT<br>Address <b>William C. Phelps</b>   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b><br><b>4:1</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b> |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><b>diabetes mellitus</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No City or Town County State  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 1968</b> to <b>Dec 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan 17 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | MD DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/>  |  | MED DIRECTOR <input type="checkbox"/>  |  | STAFF PHYSICIAN <input type="checkbox"/>                                 |  | 22c. DATE SIGNED<br><b>12/18/68</b>            |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>W F Kreuzburg</b>  |  | 22e. ADDRESS<br><b>7852 16th NW Wash DC</b>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-20-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W. Wash. D.C. 20016</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |  |  |



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| 17999   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                |  | CERTIFICATE OF DEATH   |  | 17920   |  |
|---|--|--|--|--|--|---|--|
| 1 DECEASED-NAME (Type or print) <i>Vivian EAGAN Pierce</i>  |  |  |  | 2a. DATE OF DEATH<br>Month <i>12</i> - Day <i>28</i> - Year <i>68</i>  |  | 2b. HOUR <i>8:10 PM</i>   |  |
| 3. SEX <i>Female</i>  |  | 4 RACE <i>White</i>  |  | 5 DATE OF BIRTH <i>1-18-99</i>   |  | 6 AGE (In years last birthday) <i>69</i> YRS                                      |  |
| 7a BIRTHPLACE (State or foreign country) <i>Tenn.</i>   |  | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 COUNTY OF DEATH <i>Montgomery</i>   |  |
| 10 CITY OR TOWN OF DEATH <i>Bethesda</i>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <i>Suburban</i> |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>  |  | 13b COUNTY <i>Montgomery</i>   |  | 13c CITY OR TOWN <i>Rockville</i>  |  | 13d ASIDE CITY LIM. TSP? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME First <i>Harvey</i> Middle <i>Eagan</i> Last <i>Pierce</i>   |  | 15 MOTHER'S MAIDEN NAME First <i>Bessie</i> Middle <i>Mullins</i> Last <i>Pierce</i>       |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)  |  | 16b SOCIAL SECURITY NO. <i>261 40 1073</i>  |  |
| 17 INFORMANT <i>Betty Flenner</i>   |  | Address <i>8213 Job Stuart Rd.</i>   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i><br><i>1230</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBRAL ATHEROSCLEROSIS</i><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>332x</i> (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>15 HRS</i><br><i>14 YEAR</i>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>(ESSENTIAL)</i><br><i>PULMONARY EMPHYSEMA AND CHRONIC ASTHMA. ARTERIAL HYPERTENSION</i>  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)                |  | 21f. LOCATION Street or RFD No City or Town County State   |  |   |  |
| 22a. I certify that (1) (th/s hospital) attended the deceased from <i>OCT. 9, 1965</i> , to <i>DEC. 28, 1968</i> , that (1) (we) last saw the deceased alive on <i>DEC. 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b SIGNATURE <i>James A. Roberts M.D.</i>  |  |  |  | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  | 22c. DATE SIGNED <i>DEC. 28, 1968</i>   |  |
| 22d. PHYSICIAN'S NAME (Type) <i>JAMES A. ROBERTS</i>  |  |  |  | 22e ADDRESS <i>8907 GEO. AVE. SILVER SPRING, M.D.</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>  |  | 23b. DATE <i>12/30/1968</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Southern Keys Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State) <i>Key West, Florida</i>            |  |
| 24. FUNERAL DIRECTOR <i>Jos. Gawler's Sons, Inc</i>   |  |  |  | 25a. REC'D BY REGISTRAR <i>JAN 2 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                   |  |
| 5130 <i>Wisconsin Ave. N.W. Washington, D.C.</i>  |  |  |  |  |  |   |  |



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cleared by Dr. Beldon Deep

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                 |   |                                 |  |   |   |  |  |   |                          |                       |  |
|--|--|-----------------|---|---------------------------------|--|---|---|--|--|---|--------------------------|-----------------------|--|
| Items 748 Film 408 1/6/69 kk   |  |                 |   |                                 | CERTIFICATE OF DEATH   |   |   |  |  | 17921   |                          |                       |  |
| 1. DECEASED-NAME (Type or print) <b>Victor Manuel Pina</b>   |  |                 |   |                                 | 2a. DATE OF DEATH<br>Month <b>12</b> - Day <b>24</b> - Year <b>68</b>  |   |   |  |  | 2b. HOUR <b>1:10 P.M.</b>                         |                          |                       |  |
| 3 SEX <b>Male</b>  |  | 4 RACE <b>W</b> |   | 5 DATE OF BIRTH <b>12-24-48</b> |  |   | 6 AGE (in years last birthday) <b>19</b> YRS                                      |  | 7 UNDER 1 YEAR MONTHS DAYS                   |   | 7 UNDER 24 HRS HOURS MIN |                       |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Cuba</b>  |  |                 | 7b. CIT ZEN OF WHAT COUNTRY? <b>Cuba</b>  |                                 |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Montgomery</b> Md.                             |  |   |                          |                       |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  |                 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sen &amp; Hosp</b> |                                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |   |                          |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>  |  |                 | 13b. COUNTY <b>MONTG</b>  |                                 | 13c. CITY OR TOWN <b>Takoma Park</b>                                   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>708 Ludlow St.</b> |   |                          |                       |  |
| 14. FATHER'S NAME First <b>Manuel</b> Middle <b>Victor</b> Last <b>Pina</b>  |  |                 | 15. MOTHER'S MAIDEN NAME First <b>Elena</b> Middle <b>Manuel</b> Last <b>Pina</b>                             |                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |   |  | 16b. SOCIAL SECURITY NO                      |   |                          | 17. INFORMANT Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min</b><br><b>6 hrs</b> |  |                 |   |                                 |  |   |   |  |  |   |                          |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |                 |   |                                 |  |   |   |  |  |   |                          |                       |  |
| 19a. DATE OF OPERATION   |  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |                          |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                 | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |   |  |  |   |                          |                       |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                 | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC                                    |                                 |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |   |  |  |   |                          |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1968, to <b>Dec 24</b> , 1968, that (I) (we) last saw the deceased alive on <b>Dec 3</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                 |   |                                 |  |   |   |  |  |   |                          |                       |  |
| 22b. SIGNATURE <b>James Whitlock</b>   |  |                 |   |                                 |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                           |   | 22c. DATE SIGNED <b>12-24-68</b>                                     |  |   |                          |                       |  |
| 22d. PHYSICIAN'S NAME (Type) <b>James Whitlock</b>   |  |                 |   |                                 |  | 22e. ADDRESS <b>7712 Carroll Ave Takoma Park Md</b>   |   |  |  |   |                          |                       |  |
| 23a. (BURIAL) CREMATION, (REMOVAL) (Specify)   |  |                 | 23b. DATE <b>12/27/68</b>   |                                 | 23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem Washington DC</b> |   |   | 23d. LOCATION (City or Town) (County) (State) <b>Washington DC</b>   |  |   |                          |                       |  |
| 24. FUNERAL DIRECTOR <b>W W Chambers Inc</b>   |  |                 |   |                                 |  | ADDRESS <b>8655 Ga Ave Silver Spring Md</b>   |   | 25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>                            |  | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b> |                          |                       |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |                        |  |  |
|---|--|--|--|--|--|--|--|--|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |                        |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |                        |  |  |
| 1. DECEASED-NAME (Type or print) <u>Ilario</u> First Middle Last <u>(NONE)</u> <u>PLACANICA</u>   |  |  |  |  |  | 2a. DATE OF DEATH <u>12</u> Month <u>30</u> Day <u>68</u> Year   |  |  | 2b. HOUR <u>4</u> P.M. |  |  |
| 3. SEX <u>MALE</u>  |  | 4. RACE <u>CAUC</u>  |  | 5. DATE OF BIRTH <u>5/17/90</u>  |  | 6. AGE (In years lost birthday) <u>78</u> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |                        | IF UNDER 24 HRS. HOURS MIN.                        |  |
| 7a. BIRTHPLACE (State or foreign country) <u>ITALY</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.   |  |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASHINGTON SAN. HOSP.</u>  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>CABINET MAKER</u> |                        | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <u>MARYLAND</u>  |  |  |  | 13b. COUNTY <u>MONTGOMERY</u>  |  | 13c. CITY OR TOWN <u>HYATTSVILLE</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |                        | 13e. STREET AND NUMBER <u>2402 Lewisdale Drive</u> |  |
| 14. FATHER'S NAME First Middle Last <u>Joseph</u> <u>B</u> <u>PLACANICA</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <u>Carmella</u> <u>Paschetta</u> <u>?</u>   |  |  |  |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  | 16b. SOCIAL SECURITY NO. <u>216-07-2577A</u>   |  | 17. INFORMANT <u>HOSPITAL RECORDS</u>  |  | Address  |                        |  |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u>   |  |  |  |  |  |  |  |  |                        | <u>1 day</u>                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____  |  |  |  |  |  |  |  |  |                        |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Generalized Atherosclerosis</u>  |  |  |  |  |  |  |  |  |                        | <u>Several years</u>                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>332x</u>   |  |  |  |  |  |  |  |  |                        |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                        |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or RFD No. City or Town County State  |  |  |  |  |                        |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>Dec 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |                        |  |  |
| 22b. SIGNATURE <u>Robert B. Irey</u> MD DEGREE  |  |  |  |  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>12-30-68</u>   |                        |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>  |  |  |  |  |  | 22e. ADDRESS <u>11161 New Hampshire Ave Silver Spring</u>  |  |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <u>JAN 1968</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>GATE 1 HOORAN</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Wheaton Md.</u>   |  |  |                        |  |  |
| 24. FUNERAL DIRECTOR <u>FINARDI FUNERAL HOME</u>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>7400 BRONX AVE</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                        |  |  |



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17012

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17923

|   |                          |  |   |  |  |
|---|--------------------------|--|---|--|--|
| 1 DECEASED NAME<br>(Type or Print) <b>Harry</b> First <b>Plummer</b> Last   |                          |  | 2a DATE KNOWN OF ESTI-DEATH MATEO <input checked="" type="checkbox"/> Dec 11 1968 2b HOUR <b>2:46 PM</b>  |  |  |
| 3 SEX <b>M</b>  | 4 RACE <b>Negro</b>      | 5 DATE OF BIRTH <b>Oct 10, 1910</b>  | 6 AGE (in years last birthday) <b>58</b> YRS  | IF UNDER 1 YEAR MONTHS   | IF UNDER 24 HRS HOURS MIN  |
| 7a BIRTHPLACE (State or foreign country) <b>Montg. MD</b>   |                          | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH - <b>Montgomery</b> Md   |  |
| 10 CITY OR TOWN OF DEATH <b>Rockville</b>   |                          | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>100 Dawson Ave</b> |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                          | 13b. COUNTY <b>Montgomery</b>  |   | 13c CITY OR TOWN <b>Rockville</b>  |  |
| 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                          | 13e STREET AND NUMBER <b>100 Dawson Ave.</b>   |   |  |  |
| 14 FATHER'S NAME First <b>HARRY</b> Middle <b>PLUMMER</b> Last <b>LOTTIE</b>  |                          |  | 15 MOTHER'S MAIDEN NAME First <b>SMITH</b> Middle <b>LOTTIE</b> Last <b>SMITH</b>   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                          | 16b SOCIAL SECURITY NO   |   | 17 INFORMANT <b>Mrs. MAMIE J. BUDD</b> ADDRESS <b>207 Dawson Ave Rockville, MD</b>     |  |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any/which gave rise to immediate cause (a), stating the underlying cause last <b>Cardio Vascular Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Arterio Sclerosis - Generalized.</b>                                  |                          |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden.</b><br><b>years.</b><br><b>years.</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Mellitus -</b>   |                          |  |   |  |  |
| 19a. DATE OF OPERATION  |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                          | 21b TIME OF INJURY Month, Day Year <b>19</b> HOUR A M P.M.   |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                          | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |   | 21f. LOCATION Street or R.F.D. No City or Town County State                            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                          |  |   |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b> M.O.   |                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22b. DATE SIGNED <b>Dec. 11, 1968</b>  |  |
| EXAMINER'S NAME (Type)  |                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |  |
|   |                          | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  |
|   |                          | ADDRESS (Street, city, town, or county)  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  | 23b DATE <b>12-16-68</b> | 23c NAME OF CEMETERY OR CREMATORY <b>EMORY GROVE CEM.</b>  | 23d LOCATION (City or Town) <b>EMORY GROVE, MONTG., MD</b>  | (County) (State)   |  |
| 24. FUNERAL DIRECTOR <b>ROBERT L. SNOWDEN</b>   |                          | ADDRESS <b>ROCKVILLE, MARYLAND</b>   |   | 25a REC'D. BY REGISTRAR <b>DEC 20 1968</b>   | 25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |  |
| 1 DECEASED-NAME<br>(Type or print) <b>EMMA</b>   |  |  | First Middle Last <b>POOLE</b>                                |  |  | 2a DATE OF DEATH<br>Month Day Year <b>Dec. 26, 1968</b>  |  | 2b HOUR <b>5 P. M.</b>   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br><b>Nov. 2, 1895</b>  |  | 6. AGE (In years last birthday) <b>73</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>1 24</b>        |  |
| 7a BIRTHPLACE (State or foreign country)<br><b>No. Carolina</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  |
| 1d CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Grosvenor Nursing Home</b> |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><b>Md.</b>  |  | 13b CITY OR TOWN<br><b>Montgomery</b>  |   | 13c CITY OR TOWN<br><b>Bethesda</b>  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  | 13e STREET AND NUMBER<br><b>4325-Maple Ave., Bethesda, Md.</b> |  |
| 14 FATHER'S NAME<br>First Middle Last<br><b>W. W. Peeler</b>   |  |  | 15 MOTHER'S M maiden name First Middle Last<br><b>UNKNOWN</b> |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>NO</b>   |  |  | 16b SOCIAL SECURITY NO.<br><b>246-30-8895</b>                 |  | 17 INFORMANT <b>Dorothy Seaver</b> Address<br><b>4325-Maple Ave., Bethesda, Md.</b>  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 weeks.</b>  |  |  |   |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertensive Arteriosclerotic Heart Disease</b>  |  |  |   |  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>12-22-68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour AM Month Day Year<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 |   | 21f. LOCATION Street or RFD No City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1968</b> , to <b>Dec 26, 1968</b> , that (I) ( <u>we</u> ) last saw the deceased alive on <b>12/22</b> 19 <b>68</b> , and that (in my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>not</u> ) view the body after death. |  |  |   |  |  |  |  |  |  |
| 22b SIGNATURE<br><b>J. Blaine Fitzgerald M.D.</b>  |  |  |   | DEGREE<br><b>PHYS</b>  |  | ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>12/27/68.</b>                            |  |
| 22d PHYSICIAN'S NAME (Type)<br><b>J. BLAINE FITZGERALD</b>   |  |  |   | 22e ADDRESS<br><b>8218 Wisconsin Ave. Bethesda, Maryland</b>   |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Type)  |  | 23b DATE<br><b>1-2-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville Cemetery</b>  |  | 23d LOCATION (City or Town) (County) (State)<br><b>Rockville Montg. Md.</b>  |  |  |  |
| 24 FUNERAL DIRECTOR<br><b>Robert A. Pumphreys</b>  |  |  |   | ADDRESS<br><b>7557-Wisconsin Ave., Bethesda, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 9 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>               |  |



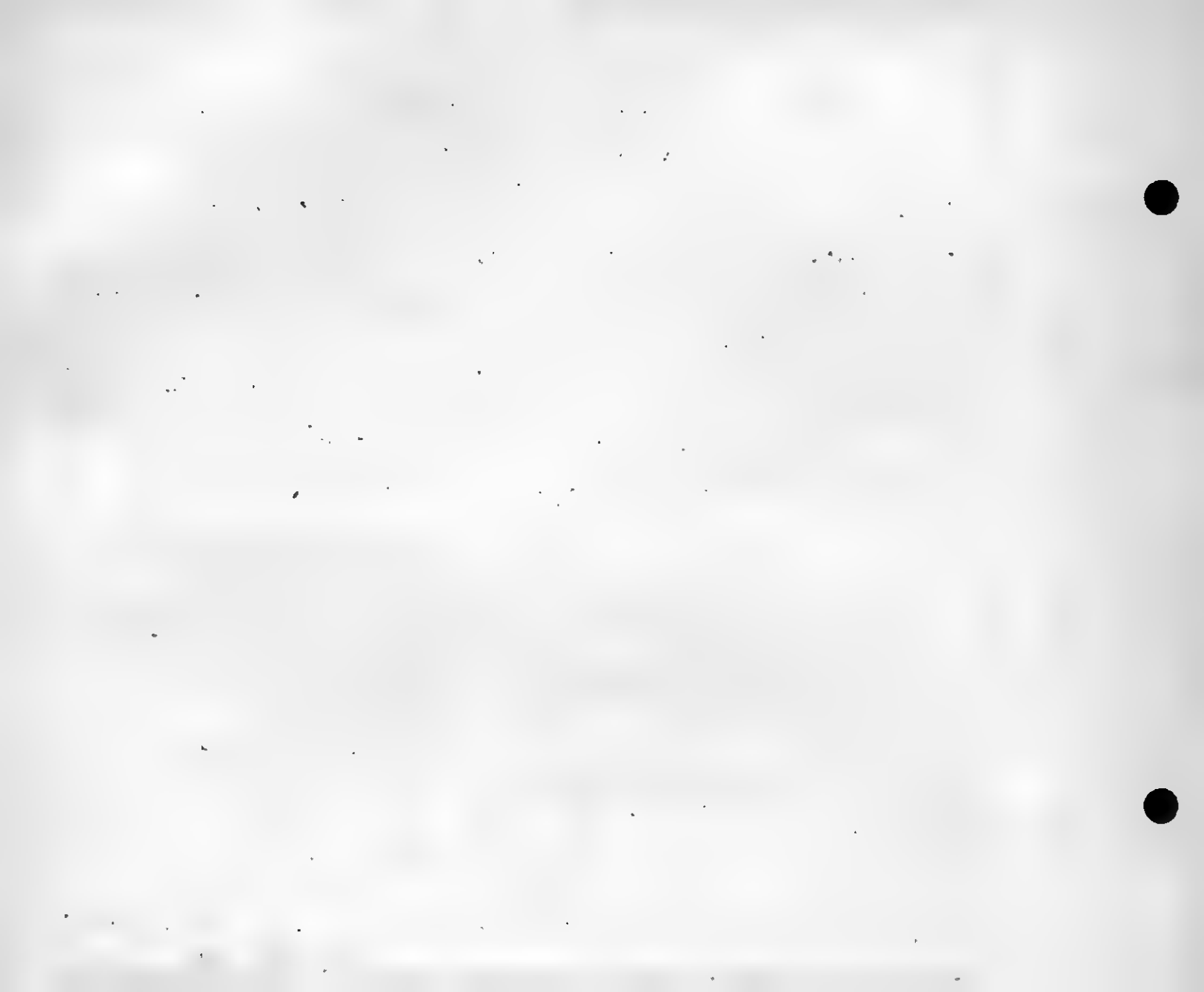
## CERTIFICATE OF DEATH

17925

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Robert William Portch</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>12</b> Day <b>23</b> Year <b>68</b> |   |  | 2b. HOUR<br><b>10 P M</b>   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br><b>Nov. 25, 1913</b>  |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. San + Hosp</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Furniture storage</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>same</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Va.</b>  |  | 13b. COUNTY<br><b>Fairfax</b>   |   | 13c. CITY OR TOWN<br><b>Falls Church</b>  |  | 13d. INSIDE CITY, #157<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>1001 Madison Lane</b>  |  | 14. FATHER'S NAME First <b>George</b> Middle <b>S.</b> Last <b>Portch</b>                               |   | 15. MOTHER'S MAIDEN NAME First <b>Olive</b> Middle <b>Troup</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Wife</b>  |  | Address<br><b>1001 Madison Lane, Falls Church</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary atherosclerosis + occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-19-68</b> , to <b>12-22-68</b> , that (I) (we) last saw the deceased alive on <b>12-22-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Boris R. Arkin</b>   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>12-23-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Boris R. Arkin</b>   |  |   |   | 22e. ADDRESS<br><b>1009 Union Blvd S.S. 50</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/26/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Mem. Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Falls Church, Virginia</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>Falls Church Funeral Home</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 27 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH  |         |  |                  |  |   |  |  |                        |                              | 17926  |
|---|---------|--|------------------|--|---|--|--|------------------------|------------------------------|--|
| 1. DECEASED NAME<br>(Type or print)   |         | First  | Middle           | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR               |                              |  |
| Core  |         | S.   |                  | Porter   | Dec. 19 68  |  |  | 4 PM                   |                              |  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                        | IF UNDER 24 HRS<br>HOURS MIN |  |
| F   | W       |  | FEB. 17, 1889    |  | 79 YRS.   |  |  |                        |                              |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                        |                              |  |
| SOUTH CAROLINA  |         | U.S.A.   |                  |  |   | MONTGOMERY Md.   |  |                        |                              |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUA. OCCUPAT ON (Kind of work done during most of working life even if retired)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |                              |  |
| KENSINGTON  |         | CARROLL HALL SANT.   |                  | SCHOOL TEACHER   |   | EDUCATION  |  |                        |                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |                              |  |
| MD  |         | MONTG  |                  | BETH.  |   |  |  | 9413 SEVEN LOCKS RD.   |                              |  |
| 14. FATHER'S NAME   |         | First  | Middle           | Last   | 15. MOTHER'S MAIDEN NAME  |  | First  | Middle                 | Last                         |  |
| Sam   |         |  |                  | Porter   | MARR  |  |  |                        | Porter                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (not known)  |         | 16b. SOCIAL SECURITY NO  |                  | 17. INFORMANT  |   | Address  |  |                        |                              |  |
| No  |         | 249-26-7027  |                  | MRS NETTIE HOWARD  |   | ARLINGTON VA.  |  |                        |                              |  |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |         |  |                  |  |   |  |  |                        |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>None</u>   |         |  |                  |  |   |  |  |                        |                              |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |                              |  |
|   |         |  |                  |  |   |  |  |                        |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                        |                              |  |
|   |         |  |                  |  |   |  |  |                        |                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)  |                  | 21f. LOCATION Street or R.F.D. No  |   | City or Town   |  | County State           |                              |  |
|   |         |  |                  |  |   |  |  |                        |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> , 19 <u>68</u> , to <u>present</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.             |         |  |                  |  |   |  |  |                        |                              |  |
| 22b. SIGNATURE  |         | 22c. DATE SIGNED   |                  |  |   |  |  |                        |                              |  |
| John B. Umhau   |         | 12/19/68   |                  |  |   |  |  |                        |                              |  |
| 22d. PHYSICIAN'S NAME (Type)  |         | 22e. ADDRESS   |                  |  |   |  |  |                        |                              |  |
| John B. Umhau   |         | 8805 Conn. Ave. Chevy Chase, Md.   |                  |  |   |  |  |                        |                              |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                        |                              |  |
| Burial  |         | Dec. 22, 1968  |                  | Sunrise Cemetery   |   | Pickens, Pickens, S.C.   |  |                        |                              |  |
| 24. FUNERAL DIRECTOR  |         | 1331 Rockville Pk. Rockville, Maryland                                       |                  | 25a. REC'D BY REGISTRAR<br>DATE DEC 23 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |                        |                              |  |
| Tyson Wheeler F. H.   |         |  |                  |  |   |  |  |                        |                              |  |



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| MARYLAND<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| 17927  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(Type or print) First Middle Last<br><b>Frank Earl Poultter</b>  |  |  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>12 25 68</b> |   |  | 2b. HOUR<br><b>6:50AM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br><b>February 5, 1900</b>   |  | 6. AGE (in years last birthday)<br><b>68</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pittsburg, Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery County</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase, Md.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>5100 Dorset Ave. apt. 507</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Building Contractor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 13e. STREET AND NUMBER<br><b>5100 Dorset Ave</b>                           |  |
| 14. FATHER'S NAME First Middle Last<br><b>Herbert (Wm) Poultter</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna (Wm) O'Brien</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO<br><b>374-09-8661</b>   |  | 17. INFORMANT Address<br><b>Thema Poultter (wife) 5100 Dorset Ave</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis with Cachexia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Carcinoma of the Esophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 months</b><br><b>1 year</b> |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>150X Emphysema</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                     |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1968, to <b>December 23, 1968</b> , that (I) (we) lost saw the deceased alive on <b>December 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Neill Kennedy, M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>December 25, 1968</b>                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. Neill Kennedy</b>  |  |  |  | 22e. ADDRESS<br><b>916-19th St. N.W., Washington, D.C.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12-28-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville Montgomery Md.</b>  |  | 23e. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc, Washington, D.C.</b> |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 2 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |



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| 17917  |  |  |  |  |  |   |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201    |  |                        |  |  |  |  |  |  |  | 17928            |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|------------------------|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (Type or print)  |  |  |  |  |  |   |  |  |   | 2a. DATE OF DEATH  |  |                        |  |  |  |  |  |  |  | 2b. HOUR         |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Wilhelmine PRADES   |  |  |  |  |  |   |  |  |   | Month Day Year<br>December 5 68  |  |                        |  |  |  |  |  |  |  | 240P M           |  |  |  |  |  |  |  |  |  |
| 3 SEX  |  |  | 4 RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6 AGE (In years last birthday)                                      |  |  | IF UNDER 1 YEAR        |  |  | IF UNDER 24 HRS.   |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Female   |  |  | Caucasian  |  |  | August 11, 1928   |  |  | 40 YRS.   |  |  | MONTHS DAYS HOURS MIN  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED  |  |  | 9. COUNTY OF DEATH  |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Germany  |  |  | USA  |  |  | WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | Montgomery  |  |  |                        |  |  | Md   |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Bethesda   |  |  | Naval Hospital   |  |  | Housewife   |  |  |   |  |  | N/A                    |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Florida  |  |  | Escambia   |  |  | Pensacola   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 3305 West Lloyd Street |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Albert Koch  |  |  |  |  | Unknown  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |  | 16b. SOCIAL SECURITY NO  |   |  |  |   | 17. INFORMANT  |  |                        |  |  | Address  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| NO   |  |  |  |  |  |   |  |  |   | Pensacola  |  |                        |  |  | Florida  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |   |  |  |   | ADRC Albert M. Prades, 3305 W. Lloyd St.                                       |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a) (b), and (c))   |  |  |  |  |  |   |  |  |   |  |  |                        |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) POST OP. REPLACEMENT OF MITRAL AND AORTIC VALVES  |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 3961 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 4.   |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |  |   | 20a. AUTOPSY?  |  |                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |   |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |                        |  |  | Yes  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year                                 |   |  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | P.M. 19  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) |   |  |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                   |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1968, to Dec. 5, 1968, that (I) (we) last saw the deceased alive on Dec. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  |  |   | DEGREE   |  |                        |  |  | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED |  |  |  |  |  |  |  |  |  |
| W. E. BEASLEY, III, M.D.   |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  | 6 Dec. 1968      |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |   |  |  |   | 22e. ADDRESS   |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| W. E. BEASLEY, III, CDR, MC, USN   |  |  |  |  |  |   |  |  |   | Naval Hospital, Bethesda, Md.  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposition   |  |  |  |  | 23b. DATE  |   |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |                        |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Cremation  |  |  |  |  | 12/7/68  |   |  |  |   | J. William Lee's Sons Co.  |  |                        |  |  | Washington D.C.  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |   |  |  |   | 25a. REC'D BY REGISTRAR  |  |                        |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| J. William Lee's Sons Co.  |  |  |  |  |  |   |  |  |   | DEC 11 1968  |  |                        |  |  | Charles Judge  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 4th and Massachusetts Ave., N.E. Washington, D.C.  |  |  |  |  |  |   |  |  |   |  |  |                        |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |

2

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 17918 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17929

|   |                            |  |  |  |  |  |  |   |  |   |  |
|---|----------------------------|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>Koy</i>  |                            | First <i>Rufus</i>   |  | Middle <i>Rufus</i>  |  | Last <i>RAINES JR.</i>   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <i>Dec-31</i> 1968 |  | 2b. HOUR <i>12:00</i> M.  |  |
| 3. SEX<br><i>male</i>   | 4. RACE<br><i>col. sk.</i> | 5. DATE OF BIRTH<br><i>1/7/24</i>  |  | 6. AGE (In years last birthday)<br><i>44</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____   |  | IF UNDER 24 HRS<br>HOURS _____ MIN _____  |  | 2c. DATE PRONOUNCED DEAD<br>Month <i>Dec</i> Day <i>31</i> Year <i>1968</i> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Georgia</i>   |                            | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>MONTGOMERY</i> Md   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>  |                            | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Suburban Hospital</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Construction</i>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Self-employed</i>                            |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><i>Illinois</i>   |                            | 13b. COUNTY<br><i>COOK</i>   |  | 13c. CITY OR TOWN<br><i>Rosell</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>R#3</i>  |  |   |  |
| 14. FATHER'S NAME<br><i>Roy</i>   |                            | First <i>Rufus</i>   |  | Middle <i>Rufus</i>  |  | Last <i>Rufus</i>  |  | 15. MOTHER'S MAIDEN NAME<br><i>Ivie</i>   |  | First <i>MAE</i> Middle <i>JAMES</i> Last <i>JAMES</i>                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>yes</i>  |                            | 16b. SOCIAL SECURITY NO.<br><i>1941-1943</i>   |  | 17. INFORMANT<br><i>Cherry RAINES - wife - odd name</i>  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <i>Cardiac Vascular Disease -</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>15 min.</i><br><i>years.</i> |                            |  |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>None</i>   |                            |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>1-2-69</i>   |                            |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><i>None</i>   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                            | 21b. TIME OF INJURY Month Day, Year<br>HOUR A.M. _____ P.M. _____ 19 _____                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)<br><i>None</i>  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                            | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><i>None</i>              |  | 21f. LOCATION Street or R.F.D. No. _____   |  | City or Town _____   |  | County _____  |  | State _____   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                 |                            |  |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>John G. Ball</i>   |                            | EXAMINER'S NAME (Type)<br><i>John G. Ball</i>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                 |  | 22b. DATE SIGNED<br><i>Dec-31-1968</i>                                      |  |
| ADDRESS (Street, city, town, or county)<br><i>None</i>  |                            |  |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)<br><i>Burial</i>   |                            | 23b. DATE<br><i>1-2-69</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Aycock Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>RFD#2 Wayne N. Carolina</i>      |  |   |  |   |  |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS<br><i>7557-Wisconsin Ave., Bethesda, Md.</i>   |                            |  |  |  |  | 25a. REC'D BY REGISTRAR<br><i>JAN 6 1969</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |  |

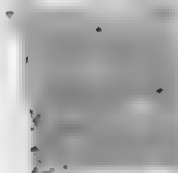




TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
|---|--|-------------------------|--|-------------------------------------|-------------------|---|--|--|---|---|-------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
| CERTIFICATE OF DEATH  |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
| 17930   |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
| 1. DECEASED NAME<br>(Type or print) <b>FRANK</b>  |  |                         | First <b>S</b>   |                                     | Middle <b>Ray</b> |   | Last   |  | 2a. DATE OF DEATH<br><b>12</b> Month <b>31</b> Day <b>68</b> Year     |   | 2b. HOUR<br><b>10:30</b> AM   |   |  |
| 3. SEX<br><b>M.</b>   |  | 4. RACE<br><b>CAUC.</b> |  | 5. DATE OF BIRTH<br><b>3/6/1877</b> |                   |   | 6. AGE (In years last birthday)<br><b>91</b> YRS |  | IF UNDER 1 YEAR<br>MONTHS   |   | IF UNDER 24 HRS.<br>HOURS MIN |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West-Read-MASS.</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                     |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.  |   |   |                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cherry Chase</b>  |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Bethesda-Silver Spring Md</b> |                                     |                   | 12a. USUAL OCCUPATION (and at work date during most of working life, even if retired.)<br><b>retired</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |   |                               |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>District of Columbia</b>  |  |                         | 13b. COUNTY<br><b>13b</b>  |                                     |                   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>5315 Conn ave NW</b> |                               |   |  |
| 14. FATHER'S NAME<br><b>Thomas</b>  |  |                         | First <b>Ray</b>   |                                     | Middle            |   | Last   |  | 15. MOTHER'S MAIDEN NAME<br><b>Ellen</b>                              |   |                               | First <b>Syna</b> Middle Last                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  |                         | 16b. SOCIAL SECURITY NO.<br><b>219-03-3868A</b>  |                                     |                   | 17. INFORMANT<br><b>Self</b>  |  |  | Address   |   |                               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |                         |  |                                     |                   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |                               |   |  |
| PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro. vascular accident</b>  |  |                         |  |                                     |                   |   |  |  |   | <b>1 hour</b>                                     |                               |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebro. vascular accident</b>  |  |                         |  |                                     |                   |   |  |  |   | <b>1 month</b>                                    |                               |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart disease</b>  |  |                         |  |                                     |                   |   |  |  |   | <b>10 years</b>                                   |                               |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |                               |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                                     |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |                               |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |                                     |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |                               |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28/1968</b> to <b>12/31/1968</b> , that (I) (we) last saw the deceased alive on <b>12/28/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                         |  |                                     |                   |   |  |  |   |   |                               |   |  |
| 22b. SIGNATURE<br><b>Edward Adelson, M.D.</b>   |  |                         |  |                                     |                   | DEGREE <b>MD</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  |  | 22c. DATE SIGNED<br><b>1/1/69</b>                                     |   |                               |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EDWARD ADELSON, M.D.</b>   |  |                         |  |                                     |                   | 22e. ADDRESS<br><b>7020 Richard Dr. Bethesda Md.</b>  |  |  |   |   |                               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                         | 23b. DATE<br><b>Jan. 6, 1969</b>   |                                     |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Medford Mass.</b> |   |                               |   |  |
| 24. FUNERAL DIRECTOR<br><b>Jos. Gawler Sons 5130 Wisc Ave NW Wash. D.C.</b>   |  |                         |  |                                     |                   | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 8 1969</b>                          |   |                               | 25b. REGISTRAR'S SIGNATURE<br><b>John G. Gage</b> |  |



... ..

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30 JAN 27 1968

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |                                   |  |
|---|--|--|--|---|--|---|--|-----------------------------------|--|
| 17090 CERTIFICATE OF DEATH 17931  |  |  |  |   |  |   |  |                                   |  |
| 1 DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR<br>M                     |  |
| HENRY JACK REID   |  |  |  |   |  | 12 27 68  |  |                                   |  |
| 3. SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| Male  |  | Negro  |  | date unknown  |  | 84 YRS  |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |
| Charlotte, N.C.   |  | USA  |  |   |  | Montgomery Md.  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Wheaton   |  |  | University Nursing Home  |   |  | Truck driver  |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived adm'ssion) STATE   |  |  | 13b. CITY OR TOWN  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |                                   |  |
| D.C.  |  |  | Washington   |   | Wash., DC  |   | 421 Tea St., NW, Wash., DC   |                                   |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |  |   |  |                                   |  |
| Lee Ike Reid  |  |  | unknown  |   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO  |   | 17 INFORMANT Address   |   |  |                                   |  |
| Yes Army  |  |  | 2410-16-711  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 weeks 6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1621  |  |  |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|   |  |  |  |   |  |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)  |  |   |  |                                   |  |
|   |  |  |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) |  | 21f. LOCATION Street or R.F.D. No   |  | City or Town  |  | County State                      |  |
|   |  |  |  |   |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-15-68, 1968, to 12-27, 1968, that (I) (we) last saw the deceased alive on 12-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |                                   |  |
| 22b. SIGNATURE <u>David A. Morowitz, M.D.</u>   |  |  |  |   | 22c. DATE SIGNED 12/27/68  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) David A. Morowitz, M.D.  |  |  |  |   | 22e. ADDRESS 9237 Three Oaks Dr., Silver Spring, Md.   |   |  |                                   |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |
| Burial  |  | 12-1-68  |  | Baltimore National  |  | Baltimore, Md.  |  |                                   |  |
| 24. FUNERAL DIRECTOR <u>U. P. Bacon</u>   |  |  |  |   | 25a. REC'D BY REGISTRAR <u>3447-145 N</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>             |                                   |  |
|   |  |  |  |   | DATE JAN 3 1969  |   |  |                                   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                           |   |  |   |
|--|---------------------------|---|--|---|
| 1 DECEASED NAME<br>(Type or Print) <i>Josephine E Rencher</i>  |                           | 2a. DATE KNOWN OF EST DEATH MATED <input type="checkbox"/> 12 18 1968   |  | 2b. HOUR <i>8:45 AM</i>   |
| 3 SEX <i>Female</i>  | 4. RACE <i>W</i>          | 5. DATE OF BIRTH <i>3/24/1898</i>   | 6. AGE (In years last birthday) <i>70</i> YRS  | 7. IF UNDER 1 YEAR MONTHS DAYS  |
| 7a. BIRTHPLACE (State or foreign country) <i>Iowa</i>  |                           | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Montgomery</i> Md   |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i>  |                           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>   |                           | 13b. COUNTY <i>Mont</i>   | 13c. CITY OR TOWN <i>Rockville</i>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |
| 14. FATHER'S NAME First Middle Last <i>Frank Etzel</i>   |                           | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Baldwine Winkelmann Edgob</i>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>   |                           | 16b. SOCIAL SECURITY NO. <i>None</i>  |  | 17. INFORMANT ADDRESS <i>Betty L. Clark Daughter 12918 Larkin Pl</i>                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>INTESTINAL OBSTRUCTION</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Valvulus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br><i>(c) METASTATIC MALIGNANT CARCINOMA TUMOR ILEUM</i>   |                           |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>2 days</i>                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                           |   |  |   |
| 19a. DATE OF OPERATION   |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                           | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)                          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                           | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |  |   |
| ACTUAL SIGNATURE <i>John G. Ball</i>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED <i>Dec 18, 1968</i>  |
| EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>   |                           | ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 23b. DATE <i>12-20-68</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl Cem.</i>   | 23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>   |   |
| 24. FUNERAL DIRECTOR ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>   |                           | 25a. RECD BY REGISTRAR DATE <i>DEC 26 1968</i>  | 25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>  |   |

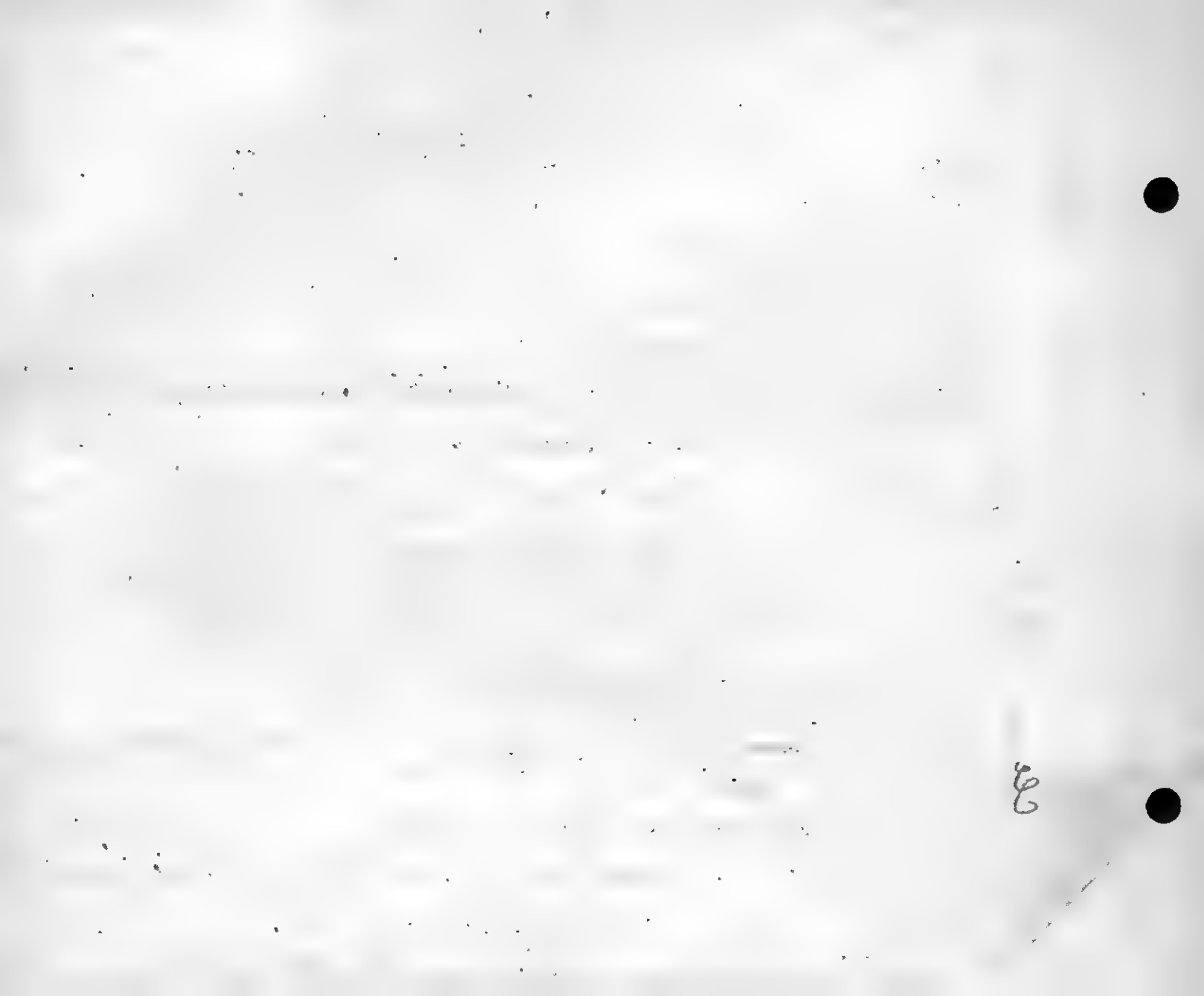


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Dr. Leop

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
|---|--|--|---|---|---|--|---------------------------------|---|----------------------------------|-------------------------------|----------------------------|
| 17932 CERTIFICATE OF DEATH 17933  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| 1 DECEASED NAME (Type or print)   |  |  |   | First Middle Last   |   |  |                                 | 2a DATE OF DEATH  |                                  |                               | 2b. HOUR                   |
| RITA Rose   |  |  |   | XX <del>ROBERTS</del> Robins  |   |  |                                 | Month Day Year<br>12 25 68  |                                  |                               | 8:30A                      |
| 3. SEX  |  | 4 RACE   |   | 5. DATE OF BIRTH  |   |  | 6. AGE (In years last birthday) |   | IF UNDER 1 YEAR MONTHS DAYS      |                               | IF OVER 24 HRS. HOURS M.N. |
| Female  |  | White  |   | 2-8-1912  |   |  | 58 56YRS                        |   |                                  |                               |                            |
| 7a BIRTHPLACE (State or foreign country)  |  |  | 7b CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH               |   |                                  |                               |                            |
| Springfield, Ill  |  |  | USA   |   |   |  | Montgomery Md.                  |   |                                  |                               |                            |
| 10 CITY OR TOWN OF DEATH  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |                                 |   | 12b KIND OF BUSINESS OR INDUSTRY |                               |                            |
| Silver Spring   |  |  | Holy Cross Hospital   |   |   | secretary  |                                 |   | Eli Lilly Co                     |                               |                            |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE   |  |  |   | 13b COUNTY  |   | 13c CITY OR TOWN   |                                 | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  | 13e STREET AND NUMBER         |                            |
| Virginia  |  |  |   | Arlington   |   | Arlington  |                                 | YES   |                                  | 1900 S Eads St. Arlington Va. |                            |
| 14 FATHER'S NAME First Middle Last  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last                                      |   |  |                                 |   |                                  |                               |                            |
| ? Callahan  |  |  |   | Mary ? O'Neill  |   |  |                                 |   |                                  |                               |                            |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) none  |  |  |   | 16b SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                 |   |                                  |                               |                            |
|   |  |  |   | 327-72-1295   |   | Mrs. David Jennings Address 12111 Edgemont   |                                 |   |                                  |                               |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| PART 1: DEATH WAS CAUSED BY:  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| IMMEDIATE CAUSE (a) Cerebral Vascular accident  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| 4560 DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| (b) Hypertension  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| (c)   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| None  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |                                  |                               |                            |
|   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b TIME OF INJURY HOUR A.M. Month Day Year                                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                                 |   |                                  |                               |                            |
|   |  | P.M. 19  |   |   |   |  |                                 |   |                                  |                               |                            |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |                                 | County  |                                  | State                         |                            |
|   |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| 22a. I certify that (I) (the hospital) attended the deceased from <del>about 3 weeks</del> 1960, to the present, that (I) (we) lost saw the deceased alive on <del>about 3 weeks</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |   |   |   |  |                                 |   |                                  |                               |                            |
| 22b. SIGNATURE  |  |  |   | DEGREE  |   | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |                                 | 22c. DATE SIGNED  |                                  |                               |                            |
| Adolph Friedman MD  |  |  |   |   |   |  |                                 | 12/25/68  |                                  |                               |                            |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |   | 22e. ADDRESS  |   |  |                                 |   |                                  |                               |                            |
| Adolph Friedman   |  |  |   | 1712 EYE ST. NW, WASH.  |   |  |                                 |   |                                  |                               |                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)   |                                 | (County)  |                                  | (State)                       |                            |
| Burial  |  | 12-28-1968   |   | Gate of Heaven Cemetery   |   | Silver Spr. Montgom.   |                                 |   |                                  | Md.                           |                            |
| 24 FUNERAL DIRECTOR   |  |  |   |   |   | 25a REC'D BY REGISTRAR   |                                 | 25b REGISTRAR'S SIGNATURE   |                                  |                               |                            |
| W. Lee Jeter  |  |  |   |   |   | JAN 3 1969   |                                 | Charles Judge   |                                  |                               |                            |
| VR A15 (11) 30M REV. 1-59 Warner E. Pumphrey, Inc. 8434 Georgia Avenue  |  |  |   |   |   |  |                                 |   |                                  |                               |                            |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 7b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408 MARYLAND STATE DEPARTMENT OF HEALTH  
1-13-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17023

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17934

|   |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
|---|--|--|-------------------|---|--|--|--|---|-------------------|--|--|--|----------|--|--|
| 1 DECEASED-NAME<br>(Type or Print)  |  |  | First Middle Last |   |  | 2a. DATE KNOWN OF DEATH                                  |  |   | Month Day Year    |  |  | 2b. HOUR                                     |          |  |  |
| Frances   |  |  | Mariam            |   |  | ROE  |  |   | 12 1 1968         |  |  | 5:20A  |          |  |  |
| 3 SEX   |  | 4 RACE   |                   | 5 DATE OF BIRTH   |  | 6. AGE (in years last birthday)                          |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |                   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |  |  | 2d. HOUR |  |  |
| Female  |  | Caucas   |                   | June 24, 1913   |  | 55 YRS   |  |   |                   | 12 8 1968                                  |  |  | 5:20A    |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |                   | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |  |  | 9 COUNTY OF DEATH                            |          |  |  |
| Massachusetts   |  |  |                   | U. S.   |  |  |  | Montgomery  |                   |  |  | Md   |          |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  |                   | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |          |  |  |
| Bethesda  |  |  |                   | Naval Hospital, Bethesda  |  |  |  | Secretary   |                   |  |  | CPA  |          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution)   |  |  |                   | 13b. CITY OR TOWN   |  |  |  | 13c. INS OF CITY, TOWN, OR VILLAGE  |                   |  |  | 13e. STREET AND NUMBER                       |          |  |  |
| Virginia  |  |  |                   | Falls Church  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                   |  |  | 304 E. Broad Street                          |          |  |  |
| 14. FATHER'S NAME   |  |  | First Middle Last |   |  | 15. MOTHER'S MAIDEN NAME                                 |  |   | First Middle Last |  |  |  |          |  |  |
| Francis   |  |  | Parker            |   |  | LOGAN  |  |   | Eleanor Witham    |  |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  |                   | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT   |                   |  |  | ADDRESS                                      |          |  |  |
| No  |  |  |                   | 030-07-0935   |  |  |  | Jack W. ROE, JR.,   |                   |  |  | 304 E. Broad St., Falls Church, Va.          |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))   |  |  |                   |   |  |  |  |   |                   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Overdose of barbiturates & alcohol  |  |  |                   |   |  |  |  |   |                   |  |  | 2 hrs.                                       |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
| 888.0   |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  |  |  | 20. AUTOPSY?  |                   |  |  |  |          |  |  |
|   |  |  |                   |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                   |  |  |  |          |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |  |                   | 21b. TIME OF INJURY Month, Day, Year  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)   |                   |  |  |  |          |  |  |
|   |  |  |                   | 3 AM Dec 1 1968   |  |  |  | Took large dose of nembutal when intoxicated  |                   |  |  |  |          |  |  |
| 22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 22a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                   |   |  | 22b. LOCATION Street or RFD No City or Town County State |  |   |                   |  |  |  |          |  |  |
|   |  | Home   |                   |   |  | 304 E. Broad St. Falls Church Va.                        |  |   |                   |  |  |  |          |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |
| ACTUAL SIGNATURE  |  |  |                   | CHIEF MEDICAL EXAMINER  |  |  |  | 22b. DATE SIGNED  |                   |  |  |  |          |  |  |
| John G. Ball  |  |  |                   | MD  |  |  |  | 8 DEC 1968  |                   |  |  |  |          |  |  |
| EXAMINER'S NAME (Type)  |  |  |                   | DEPUTY MEDICAL EXAMINER   |  |  |  |   |                   |  |  |  |          |  |  |
| JOHN G BALL MD, MONTGOMERY COUNTY,  |  |  |                   | ADDRESS (Street, city, town, or county)                                     |  |  |  |   |                   |  |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)            |  |   |                   |  |  |  |          |  |  |
| Burial  |  | 12/4/68  |                   | Arlington National Cemetery,  |  | Arlington Va.  |  |   |                   |  |  |  |          |  |  |
| 24. FUNERAL DIRECTOR  |  |  |                   |   |  | 25a. REC'D BY REGISTRAR                                  |  | 25b. REGISTRAR'S SIGNATURE  |                   |  |  |  |          |  |  |
| Falls Church Funeral Home   |  |  |                   |   |  | DEC 4 1968   |  | J. Louis Jones  |                   |  |  |  |          |  |  |
| 1102 West Broad Street, Falls Church, Va.   |  |  |                   |   |  |  |  |   |                   |  |  |  |          |  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|-------------|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Items 1, 2, 14 & 17<br>Film 408<br>1/6/69 kkk<br>17935   |  |             |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b><br>17935   |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (Type or Print)<br>First Middle Last<br>ABRAHAM Roffenbinder ROTHENBINDER   |  |             |  |  |  |  |  |  |  | 2a. DATE KNOWN OF ESTI-<br>MATED <input checked="" type="checkbox"/> Month Day Year<br>Dec. 20, 1968 9 PM  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>W |  | 5. DATE OF BIRTH<br>Aug. 14, 1885  |  | 6 AGE (In years last birthday)<br>83 YRS |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>December Day 20, Year 1968 9 PM |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Russia  |  |             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>MONTGOMERY Md   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  |             |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Suburban Hospital |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>solderer   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Jewelry                                  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br>Maryland   |  |             |  | 13b. COUNTY<br>Montgomery  |  |  |  | 13c. CITY OR TOWN<br>Bethesda  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>Edgemoor 4710 Edgemoor Lane                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME First Middle Last<br>David Roffenbinder   |  |             |  |  |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME First Middle Last<br>Pessie Gitman   |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |             |  | 16b. SOCIAL SECURITY NO<br>066-07-6007   |  |  |  | 17 INFORMANT<br>Fred Schutzman   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u><br>309.6<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>MALNUTRITION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SENILE - Atrophy of Brain</u>   |  |             |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>months<br>years  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>309.6  |  |             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |             |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |             |  |  |  |  |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |  |   |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |             |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |   |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SIGNATURE<br>EXAMINER'S NAME (Type)<br>JOHN G. BALL, M.D.  |  |             |  |  |  |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |   |  |  |  |  |  |  |  | 22b. DATE SIGNED<br>DEC. 21, 1968   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |             |  |  |  |  |  |  |  | 23b. DATE<br>12-22-68  |  |   |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>UNITED HEBREW CEMETERY                        |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>STATEN ISLAND, NEW YORK |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>BERNARD DANZANSKY & SONS   |  |             |  |  |  |  |  |  |  | ADDRESS<br>3501 14th St N.W.<br>WASH., D.C. 20010  |  |   |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE DEC 26 1968   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>f Charles Judge                            |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATE ON

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |  |   |  |  |
|---|--|--|---|---|--|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>17935</span> <span>CERTIFICATE OF DEATH</span> <span>17936</span> </div>   |  |  |   |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First Middle Last   |   |  | 2a. DATE OF DEATH  |   |  | 2b. HOUR                                     |
| Bo Christian E. ROOS  |  |  |   |   |  | Dec Month 20 Day Year 68   |   |  | M  |
| 3 SEX   |  | 4 RACE   |   | 5. DATE OF BIRTH  |  | 6 AGE (In years last birthday)   |   | 7. FUNERAL YEAR MONTHS DAYS  |  |
| Male  |  | Caucasian  |   | June 14, 1891   |  | 77 YRS.  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH  |   |  |  |
| California  |  | USA  |   |   |  | Montgomery Md  |   |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Bethesda  |  |  | Naval Hospital  |   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| Virginia  |  |  |   |   | Arlington  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 2111 Jefferson Davis Hwy.                    |
| 14 FATHER'S NAME First Middle Last  |  |  | 15 MOTHER'S MAIDEN NAME First Middle Last                                   |   |  |  |   |  |  |
| Bo Christian ROOS   |  |  | Anna Butt   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |   | 17 INFORMANT Address   |  |   |  |  |
| Yes   |  |  | 505467288   |   | Hospital records   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))   |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |  |   |  |  |
| IMMEDIATE CAUSE (a) PNEUMONIA   |  |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |  |   |  |  |
| (b)   |  |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |  |   |  |  |
| (c)   |  |  |   |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |   |  |  |
| 493X  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) |  |   |  |  |
|   |  |  |   |   |  |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No City or Town County State   |  |  |   |  |  |
|   |  |  |   |   |  |  |   |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from November 26, 1968, to December 20, 1968, that (A) (we) last saw the deceased alive on December 20, 1968, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE John R. Fletcher DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  |  |   |   | 22c. DATE SIGNED 21 December 1968  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) John R. FLETCHER LCDR MC USN   |  |  |   |   | 22e. ADDRESS   |  |   |  |  |
|   |  |  |   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |  |  |
| Burial  |  | 12-21-68   |   | Forest Lawn   |  | Glendale, California   |   |  |  |
| 24. FUNERAL DIRECTOR Everly-Wheatley ADDRESS  |  |  |   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Funeral Home, Braddock Road, Alexandria, Va.  |  |  |   |   | DATE DEC 27 1968   |  | Charles Judge   |  |  |



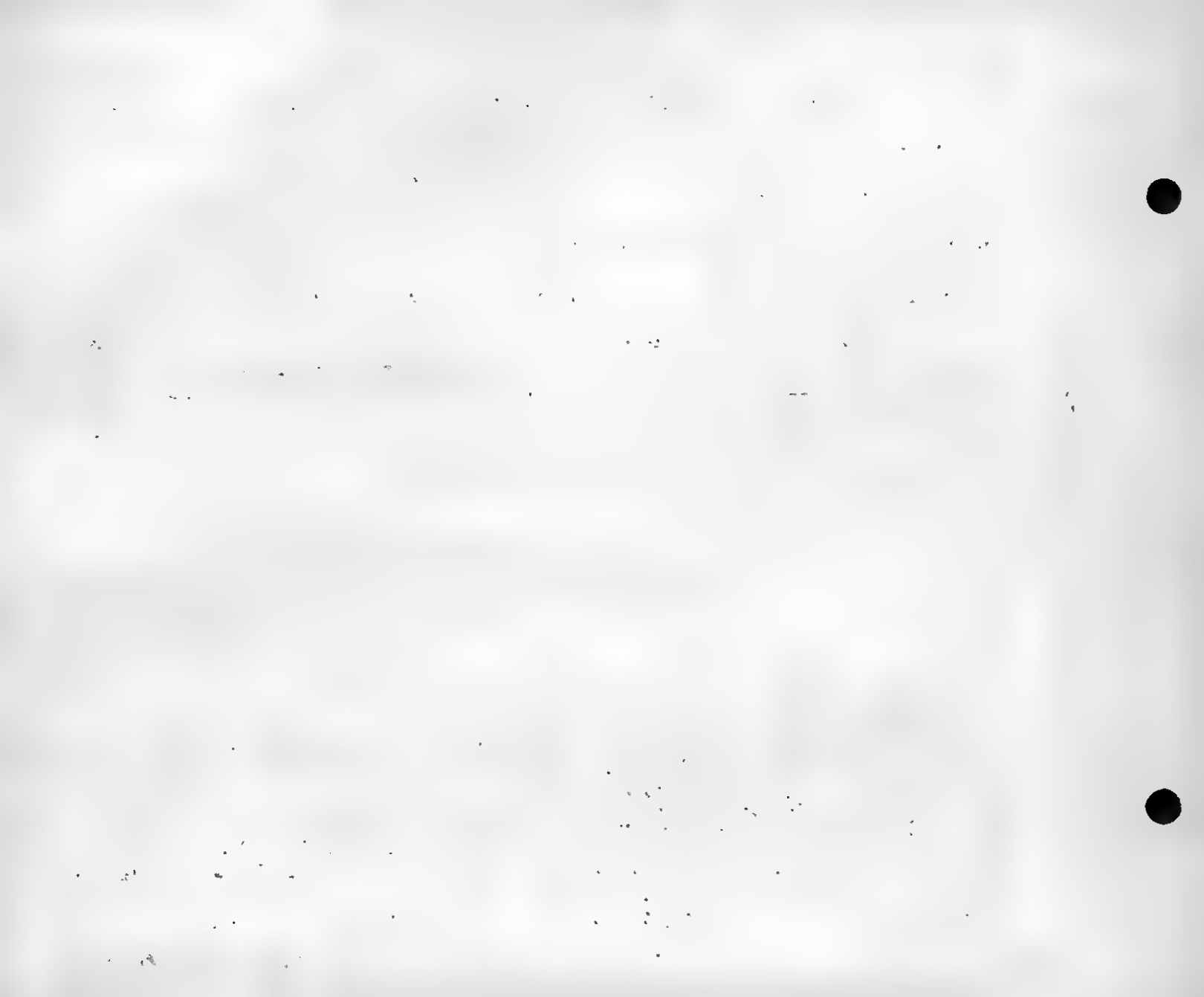
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

|   |  |   |   |  |  |   |  |   |  |
|---|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>Terry Lewis Root</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>December</b> Day <b>28</b> Year <b>1968</b>                         |  |  | 2b. HOUR<br><b>11:35</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>20 June 1958</b>  |  | 6. AGE (In years last birthday)<br><b>10</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>The Clinical Center, NIH</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Student</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Pennsylvania</b>  |  | 13b. COUNTY<br><b>Lancaster</b>   |   | 13c. CITY OR TOWN<br><b>Lancaster</b>  |  | 13d. INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  | 13e. STREET AND NUMBER<br><b>722 Fourth Street</b>              |  |
| 14. FATHER'S NAME First Middle Last<br><b>Walter Root</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Esther Winters</b>                               |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No --</b>         |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  |   | 17. INFORMANT <b>Bethesda, Maryland 20014</b><br><b>The Medical Records, The Clinical Center,</b> |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia and sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute Lymphocytic Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>3 Years</b> |  |   |   |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>2014</b>   |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |
| 22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>21 October, 1968</b> , to <b>28 Dec.</b> , 19 <b>68</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>28 December</b> , 19 <b>68</b> and that in <del>(X)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(X)</del> (we) (did) (did not) view the body after death.  |  |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Brian W. Goodell, M.D.</b>   |  |   |   | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>28 December 1968</b>                     |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Brian W. Goodell, M. D.</b>  |  |   |   | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>Dec 31, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rawlinsville V. Meth. Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hollywood RD Lancaster Co., Pa.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Paul Reynolds, Jr. Quarryville, Pa.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 3 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |



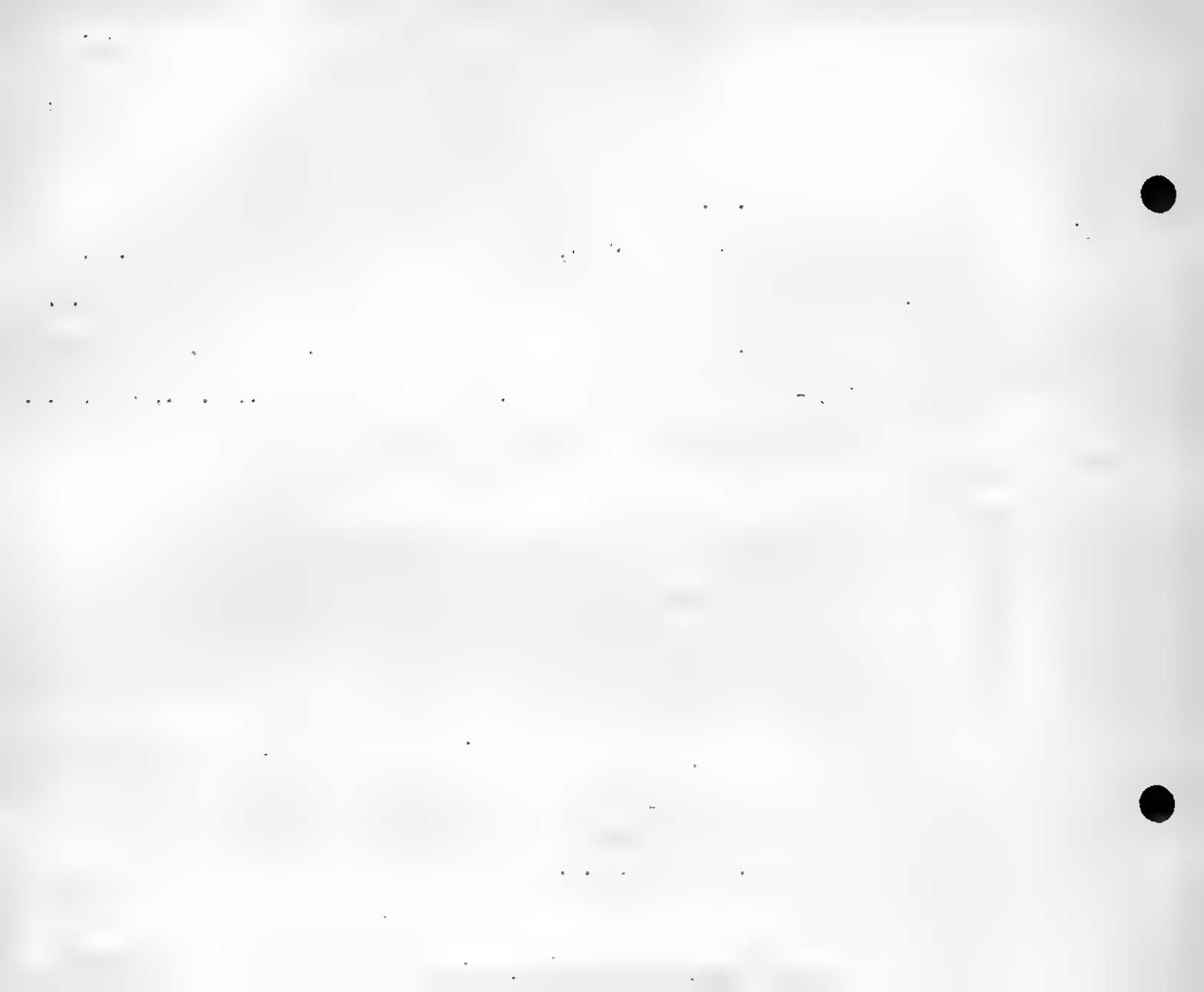


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                         |  |   |  |  |                           |  |
|--|--|---|-------------------------|--|---|--|--|---------------------------|--|
| 179327 CERTIFICATE OF DEATH 17938  |  |   |                         |  |   |  |  |                           |  |
| 1 DECEASED NAME<br>(Type or print)   |  |   | First Middle Last       |  |   | 2a DATE OF DEATH   |  | 2b. HOUR                  |  |
| David Thomas ROPER   |  |   |                         |  |   | Month 12 Day 1 Year 1968   |  | 2:00 PM                   |  |
| 3. SEX   |  | 4. RACE   |                         | 5. DATE OF BIRTH   |   | 6 AGE (In years last birthday)   |  | F UNDER 1 YEAR            |  |
| Male   |  | Negroid   |                         | October 26, 1918   |   | 50 YRS.  |  | MONTHS DAYS HOURS MIN     |  |
| 7a BIRTHPLACE (State or foreign country)   |  | 7b CITIZEN OF WHAT COUNTRY?   |                         | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 COUNTY OF DEATH  |  | Md                        |  |
| South Carolina   |  | U. S.   |                         |  |   | Montgomery   |  |                           |  |
| 10 CITY OR TOWN OF DEATH   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                         | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                           |  |
| Bethesda   |  | Naval Hospital, Bethesda  |                         | Steward  |   | U. S. Navy   |  |                           |  |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b COUNTY  |                         | 13c CITY OR TOWN   |   | 13d HOME CITY LIM. TS?   |  | 13e STREET AND NUMBER     |  |
| Dist. of Columbia  |  |   |                         | Washington   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1624 Portal Drive, N.W.   |  |
| 14 FATHER'S NAME   |  |   | 15 MOTHER'S MAIDEN NAME |  |   |  |  |                           |  |
| First Middle Last  |  |   | First Middle Last       |  |   |  |  |                           |  |
| Porcher D. ROPER   |  |   | Jennie F. FRASIER       |  |   |  |  |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |   | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT Address  |  |  |                           |  |
| YES 1938-1958  |  |   |                         |  | Mrs. Florice ROPER Dr., N. W., Wash. D.C.                           |  |  |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))   |  |   |                         |  |   |  |  |                           |  |
| PART 1 DEATH WAS CAUSED BY.  |  |   |                         |  |   |  |  |                           |  |
| IMMEDIATE CAUSE (a) Carcinoma of the colon with widespread metastases  |  |   |                         |  |   |  |  |                           |  |
| 1538 DUE TO, OR AS A CONSEQUENCE OF  |  |   |                         |  |   |  |  |                           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |                         |  |   |  |  |                           |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |   |                         |  |   |  |  |                           |  |
| (c)  |  |   |                         |  |   |  |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |                         |  |   |  |  |                           |  |
| 153  |  |   |                         |  |   |  |  |                           |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                         |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                           |  |
|  |  |   |                         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES  |                           |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b TIME OF INJURY  |                         | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |   |  |  |                           |  |
|  |  | HOUR A.M. Month Day Year P.M. 19  |                         |  |   |  |  |                           |  |
| 21d INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)  |                         | 21f. LOCATION  |   | City or Town   |  | County State              |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |                         | Nov. 12, 1968  |   |  |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1968, to Dec. 1, 1968, that (I) (we) last saw the deceased alive on Dec. 1, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. |  |   |                         |  |   |  |  |                           |  |
| 22b. SIGNATURE   |  |   |                         | DEGREE   |   | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> |  | 22c DATE SIGNED           |  |
| Halbert E. Ashworth, MD  |  |   |                         |  |   |  |  | Dec. 2, 1968              |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |                         | 22e ADDRESS  |   |  |  |                           |  |
| Halbert E. ASHWORTH, M.D.  |  |   |                         | Naval Hospital, Bethesda, Md.  |   |  |  |                           |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b DATE  |                         | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION (City or Town)  |  | (County) (State)          |  |
| Burial   |  | 12/5/68   |                         | Arlington National Cemetery  |   | Arlington  |  | Va.                       |  |
| 24. FUNERAL DIRECTOR   |  |   |                         | ADDRESS  |   | 25a REC'D BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE |  |
| Frazier Funeral Home   |  |   |                         | 389 Rhode Island Ave. N.W. Washington, D.C.  |   | DEC 5 1968   |  | Charles Judge             |  |



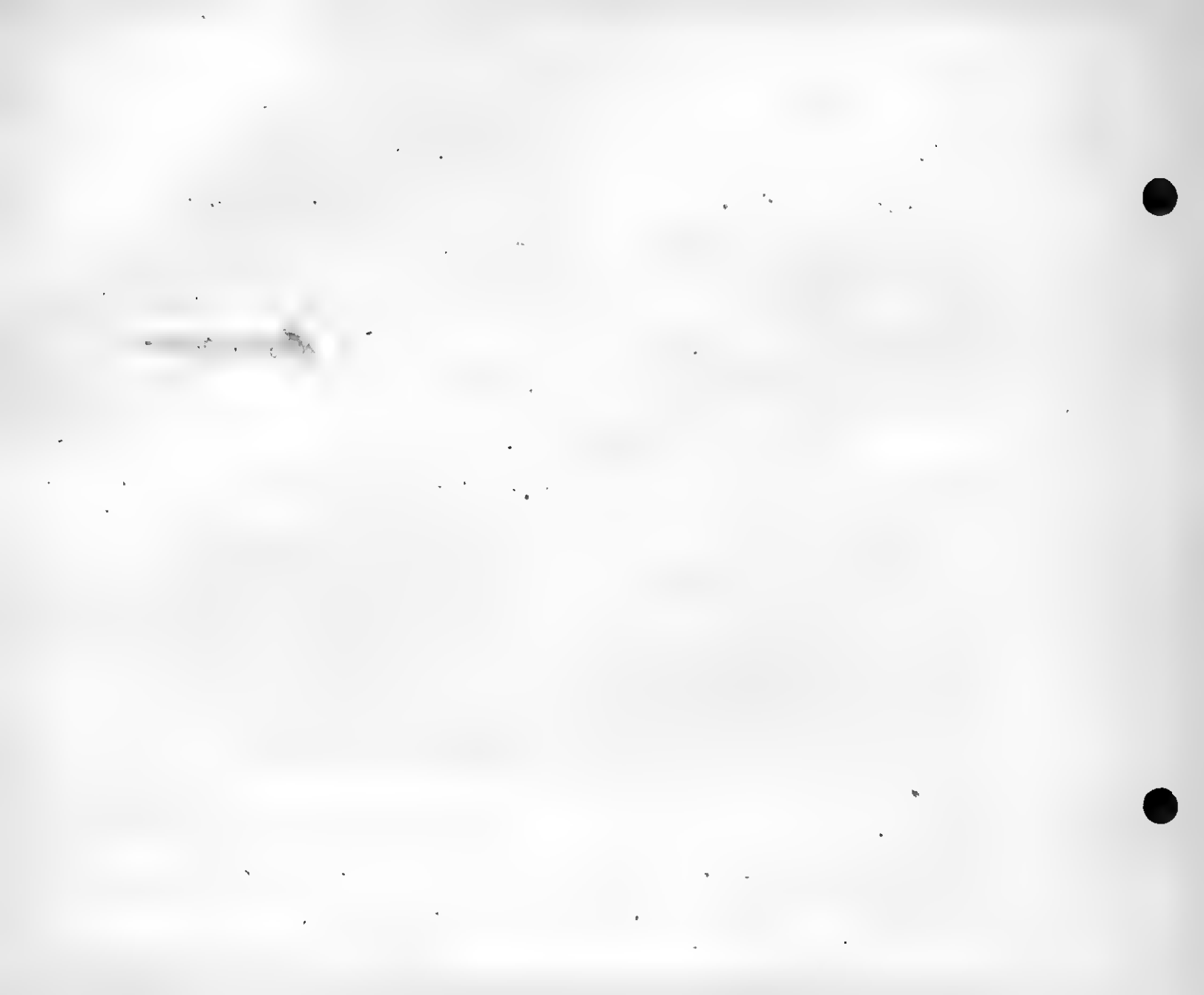
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>JOSEPH</b>  |  |  |  |   |  | First   |  | Middle  |  | Last  |  |
| 2. DATE OF DEATH<br><b>12-25-68</b>  |  |  |  |   |  | Month   |  | Day   |  | Year  |  |
| 3. SEX<br><b>M</b>   |  |  |  |   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>8-17-92</b>  |  | 6. AGE (In years last birthday)<br><b>76</b> YRS  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>POLAND</b>   |  |  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  |  |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>CHEVY CHASE NURSING CENTER</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>FURRIER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>D.C.</b>   |  |  |  |   |  | 13b. CITY OR TOWN<br><b>WASHINGTON</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>1937 LAMONT ST. N.W.</b>                                     |  |
| 14. FATHER'S NAME<br><b>ABRAHAM</b>  |  |  |  |   |  | First   |  | Middle  |  | Last  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>IDA</b>   |  |  |  |   |  | First   |  | Middle  |  | Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>YES</b>   |  |  |  |   |  | (If yes give war or dates of service)<br><b>WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-48-1563</b>  |  | 17. INFORMANT <b>WIFE</b><br><b>Helen Rosendorf</b> Address<br><b>1937 Lamont St N.W.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>100X</b> <b>Pyelonephritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of Urinary Bladder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1810</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:<br><b>3 MONTHS</b><br><b>2 years</b>        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arterio-Sclerosis - aed C. V. H.</b>   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>             |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |   |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>68</b> , to <b>12/25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                                   |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Samuel Dessoff</b>  |  |  |  |   |  | DEGREE  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>12/25/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>SAMUEL DESSOFF</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>1302-18 ST. N.W.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE<br><b>12-27-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ADAS ISRAEL CEMETERY</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WASH. D.C.</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>BERNARD DAVIZANSKY &amp; SONS</b><br><b>3501-14 16 ST N.W. WASH. D.C.</b>   |  |  |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 30 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
TOM REV 1.68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17940

|  |  |   |   |  |
|--|--|---|---|--|
| 1. DECEASED NAME<br>(Type or Print) <b>Joseph A. ROSSELL</b>   |  | 2a. DATE KNOWN OF DEATH<br>EST <input type="checkbox"/> Mated <input type="checkbox"/> <b>Dec. 14 1968</b>  |   | 2b. HOUR <b>500P</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Cauc</b>   | 5. DATE OF BIRTH<br><b>Jul. 25, 82</b>  | 6. AGE (In years) <b>86</b><br>MONTHS <b>YRS</b>  | 7. IF UNDER 1 YEAR<br>MONTHS <b>DAYS</b>   |
| 7a. BIRTHPLACE (State or foreign)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Montgomery</b>  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Naval Hospital</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during normal working life, even if retired)<br><b>USMC</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before)<br><b>District of Columbia</b>  |  | 13b. CITY OR TOWN<br><b>Washington</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>2101 16th St., N. W.</b>  |
| 14. FATHER'S NAME<br><b>John Settles Rossell</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Sarah McCaffery</b>  |   |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO<br><b>1901-45 230 40 4167</b>   | 17. INFORMANT<br><b>Arlington, Va. Mrs. Florence Tolson, 3422 S. Wakefield</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho Pneumonia Bilateral.</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days -</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Fracture of Right Hip</b>  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br><b>7:15 AM, Nov 13 1968</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)<br><b>Fall in lobby of Hotel where he lived</b>                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Hotel</b> | 21f. LOCATION Street or R.F.D. No City or Town County State<br><b>2101 16th St. NW Washington D.C.</b>  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>Dec. 16, 1968</b>   |
| EXAMINER'S NAME (Type)<br><b>John G. Ball, M. D.</b>   |  | ADDRESS (Street, city, town, or county)   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>12-18-68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery Arlington Va.</b>  | 23d. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>Everly-Wheatley, 1500 West Braddock Rd. Alexandria, Virginia.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 19 1968</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |                       |   |  |   |   |   |  |  |
|---|--|---|--|---|-----------------------|---|--|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |                       |   |  |   |   |   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |                       |   |  |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br><i>FANNIE</i>   |   | Middle                |   | Last<br><i>ROTKIN</i>                                |   | 2a. DATE OF DEATH<br>Month <i>12</i> Day <i>25</i> Year <i>68</i>         |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>                       |  | 5. DATE OF BIRTH<br><i>9/21/76</i>  |                       |   | 6. AGE (In years<br>lost birthday)<br><i>92</i> YRS. |   | 2b. HOUR<br><i>11:57</i> M  |   |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. COUNTY OF DEATH<br><i>MONTGOMERY</i> Md.   |  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>SILVER SPRING</i>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><i>Holy Cross Hosp.</i> |   |                       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br><i>H.W.</i>  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                      |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before<br>admission) STATE<br><i>MD</i>   |  |   | 13b. COUNTY<br><i>Washington D.C.</i>  |   |                       | 13c. CITY OR TOWN<br><i>Washington D.C.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>1125 Spring Rd. N.W.</i> |  |  |
| 14. FATHER'S NAME<br>First<br><i>Benjamin</i>   |  |   | Middle<br><i>Rotkin</i>  |   | Last<br><i>Rotkin</i> |   | 15. MOTHER'S MAIDEN NAME<br>First<br><i>Sarah</i>    |   |   | Middle<br><i>Wishnevsky</i>                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO<br><i>-</i>  |   |                       | 17. INFORMANT<br><i>Benj. Bell Nephew,</i>  |  |   | Address<br><i>9707 Old George Rd.<br/>Bethesda, Md.</i>                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonitis</i><br><i>486X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>storing the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |                       |   |  |   |   | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>422X</i><br><i>Arteriosclerotic Heart Disease</i>  |  |   |  |   |                       |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   |                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC)                             |   |                       | 21f. LOCATION Street or R.F.D. No   |  |   | City or Town  |   | County   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-17-68</i> , to <i>12-21-68</i> , that (I) (we) last<br>saw the deceased alive on <i>12-21-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |   |                       |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Abraham W. Danzansky</i>   |  |   |  |   |                       | DEGREE<br>ATTENDING<br>PHYS <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><i>12-25-68</i>                                       |   |  |  |
| 22d. PHYSICIAN<br>NAME (Type)<br><i>ABRAHAM W. DANZANSKY</i>  |  |   |  |   |                       | 22e. ADDRESS<br><i>1106 SPRING ST S.S. MD</i>   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>12/27/68</i>   |   |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King David Mem. Garden</i>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Falls Church, Va.</i> |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>Bernard Danzansky &amp; Sons</i>   |  |   |  |   |                       | ADDRESS<br><i>3501 14th St Wash., D.C.</i>  |  |   | 25a. REGO BY REGISTRAR<br>DATE<br><i>DEC 30 1968</i>                      |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |                              |
|---|--|--|--|--|--|---|--|--|--|------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |  |                              |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |                              |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Simon   |  | Middle<br>NMI  |  | Last<br>Rudman  |  | 2a. DATE OF DEATH<br>12 Month 16 Day 68 Year |  | 2b. HOUR<br>2:05 PM          |
| 3 SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br><del>XXXXXX</del> 5/9/02   |  | 6 AGE (In years<br>last birthday)<br>68 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  | IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br>Russia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>MONTGOMERY CITY   |  |  |  |                              |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Helen C. ... |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Salesman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Furniture  |  |  |  |                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br>Md  |  | 13b. COUNTY<br>MONTGOMERY  |  | 13c. CITY OR TOWN<br>S.S.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2312 Colston Drive |  |                              |
| 14. FATHER'S NAME<br>Ben  |  | First<br>Middle<br>Last<br>Rudman  |  | 15. MOTHER'S MAIDEN NAME<br>Sarah  |  | First<br>Middle<br>Last<br>-----  |  |  |  |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>No  |  | (If yes give war or dates of service)<br>-----   |  | 16b. SOCIAL SECURITY NO<br>unknown   |  | 17 INFORMANT<br>Mrs. ...  |  | Address                                      |  |                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC COLON CANCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) ...<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ...<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>34 1/2 YRS |  |  |  |  |  |   |  |  |  |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |                              |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 1906, 19, to 12 16, 1968, that (I) (we) last saw the deceased alive on Dec 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did), (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |                              |
| 22b. SIGNATURE<br>Robert Kravitz MD   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                    |  | 22c. DATE SIGNED<br>12 16-68  |  |  |  |                              |
| 22d. PHYSICIAN'S NAME (Type)<br>ROBERT KRAVITZ  |  | 22e. ADDRESS<br>3184 - 16th ST. S.S. Md 2010   |  |  |  |   |  |  |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>12-17-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dalton Cem.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Dalton, Pa.                                    |  |  |  |                              |
| 24. FUNERAL DIRECTOR<br>Goldberg ...  |  | ADDRESS<br>4213 9th St NW Wash D.C.  |  | 25a. REC'D BY REGISTRAR<br>DEC 19 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |                              |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |                                    |  |  |   |  |   |
|--|---------|------------------------------|--|--|------------------------------------|--|--|---|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |  |                                    |  |  |   |  |   |
| 1. DECEASED NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |                                    | 2a. DATE KNOWN OF DEATH  |  |   | 2b. HOUR                                     |   |
| Mammie   |         |                              | None   |  |                                    | Dec 31 1968  |  |   | 7 P M  |   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                    | IF UNDER 24 HRS<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD                        | 2d. HOUR                                     |   |
| Fe   | W       | Jan 1, 1894                  | 74 YRS   |  |                                    |  |  | Dec 31 1968                                     | 7 P M  |   |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |   |  |   |
|  |         | U.S.A.                       |  |  |                                    | Montgomery Md  |  |   |  |   |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |   |
| Gaithersburg   |         |                              | 7932 Muncester Mill Rd   |  |                                    |  |  |   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              |  | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 13e. STREET AND NUMBER                          |  |   |
| West Virginia  |         |                              |  | Eggleston  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | 7   |  |   |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |  |   |  |   |
| First Middle Last  |         |                              | First Middle Last  |  |                                    |  |  |   |  |   |
| UNKNOWN  |         |                              | UNKNOWN  |  |                                    |  |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS  |  |   |  |   |
| NO   |         |                              |  |  |                                    |  |  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |                                    |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.<br>4119<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |                              |  |  |                                    |  |  |   | Sudden                                       |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |                              |  |  |                                    |  |  |   |  |   |
| 19a. DATE OF OPERATION   |         |                              |  |  |                                    |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |
| 19a. DATE OF OPERATION   |         |                              |  |  |                                    |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |
| 20. AUTOPSY?   |         |                              |  |  |                                    |  |  |   |  |   |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |         |                              |  |  |                                    |  |  |   |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                       |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)        |  |   |  |   |
|  |         |                              |  |  |                                    |  |  |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or RFD No City or Town County State                               |  |   |  |   |
|  |         |                              |  |  |                                    |  |  |   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |                                    |  |  |   |  |   |
| ACTUAL SIGNATURE   |         |                              | John S. Ball   |  |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   | 22b. DATE SIGNED                             |   |
| EXAMINER'S NAME (Type)   |         |                              |  |  |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                    |  |   | Jan 1, 1969                                  |   |
|  |         |                              |  |  |                                    | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                            |  |   |  |   |
|  |         |                              |  |  |                                    | ADDRESS (Street, city, town, or county)  |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATED ON (City or Town) (County) (State) |  |   |
| Removal  |         |                              | 1-1-69   |  | Hinkel Funeral Home                |  |  | Davis, West Va.                                 |  |   |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS  |  |                                    | 25a. REC'D BY REG STRAR  |  | 25b. REG STRAR'S SIGNATURE                      |  |   |
| Robert V. Snowden  |         |                              | Rockville, Md.   |  |                                    | JAN 6 1969   |  | Charles Judge                                   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |      |   |  |   |                 |
|--|--|---|---|---|------|---|--|---|-----------------|
| CERTIFICATE OF DEATH   |  |   |   |   |      |   |  |   |                 |
| 1 DECEASED NAME<br>(Type or print)   |  |   | First   | Middle  | Last | 2a DATE OF DEATH<br>Month   |  | Day   | Year            |
| Nettie Peachie Sampson   |  |   |   |   |      | Dec   |  | 27  | 1968            |
| 3 SEX  |  | 4 RACE  |   | 5 DATE OF BIRTH   |      | 6 AGE (In years last birthday)  |  | 2b HOUR   |                 |
| Female   |  | White   |   | Dec 15, 1878  |      | 90 YRS  |  | 5:43 PM   |                 |
| 7a BIRTHPLACE (State or foreign country)   |  | 7b CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9 COUNTY OF DEATH   |  |   |                 |
| Madison, Va.   |  | U.S.  |   |   |      | Monterey  |  | Md.   |                 |
| 1d CITY OR TOWN OF DEATH   |  |   | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)      |  | 2b KIND OF BUSINESS OR INDUSTRY                                     |                 |
| Winny, Ind.  |  |   | Brook Grove Foundation  |   |      | Housewife   |  | None  |                 |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  |  |   | 13b CITY OR TOWN  |   |      | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET AND NUMBER   |                 |
| Ind.   |  |   | Winny, Ind.   |   |      | YES   |  | 4707 Sheridan St.   |                 |
| 14 FATHER'S NAME   |  |   | First   | Middle  | Last | 15. MOTHER'S MAIDEN NAME  |  |   | First           |
| Henry B  |  |   |   |   |      | Rachel G  |  |   |                 |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)  |  |   | 16b SOCIAL SECURITY NO.   |   |      | 17 INFORMANT  |  |   | Address         |
| No   |  |   |   |   |      | Nettie Laman  |  |   | Riversdale, Ind |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2509  |  |   |   |   |      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                 |
| DUE TO, OR AS A CONSEQUENCE OF Diabetes Mellitus   |  |   |   |   |      |   |  | 2 days  |                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |   |   |      |   |  | 1 YRS   |                 |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |   |      |   |  |   |                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |      |   |  |   |                 |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |   |      | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                 |
|  |  |   |   |   |      |   |  |   |                 |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b TIME OF INJURY  |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)   |      |   |  |   |                 |
|  |  | HOUR AM PM Month Day Year   |   |   |      |   |  |   |                 |
| 21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC |   | 21f LOCATION  |      | Street or R.F.D. No   |  | City or Town  |                 |
|  |  |   |   |   |      |   |  |   |                 |
| 22a I certify that (I) (this hospital) attended the deceased from 1964 to 12/27/68, that (I) (we) last saw the deceased alive on 12/27/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death |  |   |   |   |      |   |  |   |                 |
| 22b SIGNATURE  |  |   |   |   |      | DEGREE  |  | 22c DATE SIGNED   |                 |
| C.H. Ligon M.D.  |  |   |   |   |      | MED. DIRECTOR   |  | 12/27/68  |                 |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |   |   |      | 22e ADDRESS   |  |   |                 |
| C.H. Ligon M.D.  |  |   |   |   |      | SANDY SPRING MD, 20860  |  |   |                 |
| 23a BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b DATE  |   | 23c NAME OF CEMETERY OR CREMATORY   |      | 23d LOCATION (City or Town)   |  | (County) (State)  |                 |
| Burial   |  | Dec 30, 1968  |   | Ft Lincoln Cemetery   |      | Colmar Manor  |  | Pro Geo Md.   |                 |
| 24 FUNERAL DIRECTOR  |  |   |   | ADDRESS   |      | 25a REC'D BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE   |                 |
| P. Gasch's Sons  |  |   |   | Hyattsville, Md.  |      | JAN 3 1969  |  | Charles Judge   |                 |



# FOR STATE HEALTH DEPT.

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Items 18-22a Film 408 MARYLAND STATE DEPARTMENT OF HEALTH  
1-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17945

|   |                         |  |  |  |   |   |   |   |   |  |                                 |
|---|-------------------------|--|--|--|---|---|---|---|---|--|---------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Fred Harvey Sanders</b>   |                         |  | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month Day Year<br><b>Dec 13, 1968</b>                              |   |   | 2b. HOUR<br>M<br><b>12</b>                            |  |                                 |
| 3 SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br><b>Dec 20, 1942</b>  | 6. AGE (in years last birthday)<br><b>25 YRS</b>                             | 7. UNDER 1 YEAR<br>MONTHS DAYS   |   | 8. UNDER 24 HRS<br>HOURS MIN  |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>12 13 68</b>                       |   |  | 2d. HOUR<br>M<br><b>5:30 PM</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md</b>  |                         | 7b. CIT ZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Dec 13, 1968 Montgomery Md.</b>  |   |   |   |  |                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Id Silver Spring</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Holy Cross hospital</b> |  |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Electrical</b>                                 |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineer</b>  |  |                                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |                         |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>5403 Manorfield Road</b> |  |                                 |
| 14. FATHER'S NAME<br><b>Lawson F Sanders</b>  |                         |  | First Middle Last  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Marjorie Gruver</b>  |   |   | First Middle Last                                     |  |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>  |                         |  | (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO<br><b>214 42 6850</b>   |   |   | 17. INFORMANT<br><b>Lawson F. Sanders</b>             |  |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound in head, apparently</b><br><b>20 X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>self inflicted</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                         |  |  |  |   |   |   |   |   |  |                                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>976 X Acute severe depression</b>   |                         |  |  |  |   |   |   |   |   |  |                                 |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |                                 |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>12-13 19 68</b> |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)<br><b>Deceased, depressed, shot self in head with pistol</b> |   |   |   |  |                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>                |  |  | 21f. LOCATION Street or R.F.D. No City or Town County State<br><b>5403 Manorfield Road Rockville Montg. Md.</b> |   |   |   |   |  |                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |  |   |   |   |   |   |  |                                 |
| ACTUAL SIGNATURE<br><b>Belven R. Reap</b>   |                         |  | M.D.   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | 22b. DATE SIGNED<br><b>Dec 14, 1968</b>               |  |                                 |
| EXAMINER'S NAME (Type)<br><b>BELVEN R. REAP</b>   |                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |   | ADDRESS (Street, P.O. box, or county)   |   |   |   |  |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>Dec 17, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington</b>   |   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyattsville Pro Geo Md.</b>     |   |  |                                 |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>  |                         |  |  |  |   | ADDRESS<br><b>Hyattsville, Md</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>DEC 18 1968</b>                               |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |                                 |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

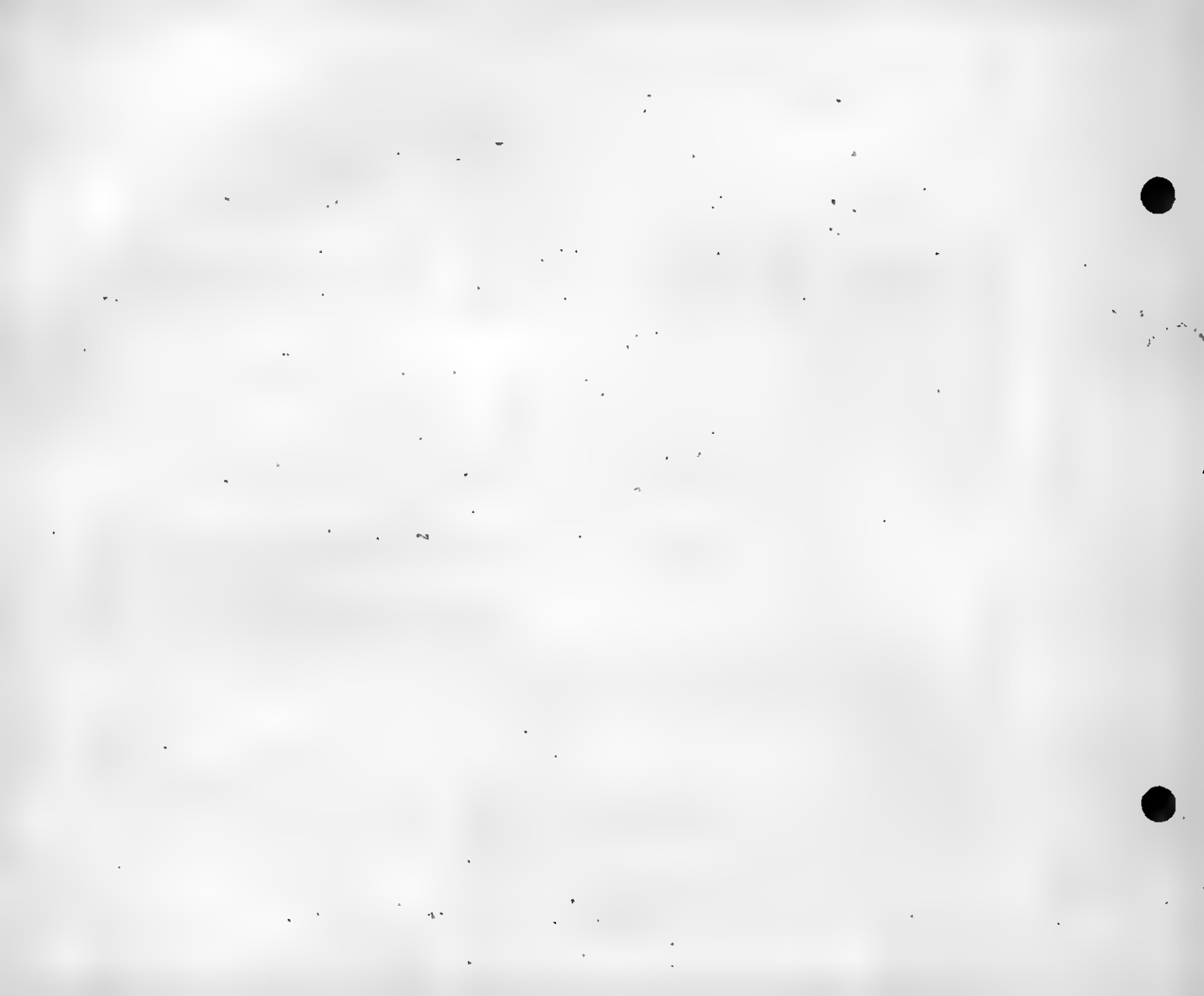
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17025

17946

|  |  |   |   |   |   |   |  |   |  |  |
|--|--|---|---|---|---|---|--|---|--|--|
| 1 DECEASED NAME<br>(Type or print) <b>BETTY JO SAWYER</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>Dec</b> Day <b>12</b> Year <b>68</b>                                      |   |   | 2b. HOUR<br><b>1:40 AM</b>  |  |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>                        |   | 5. DATE OF BIRTH<br><b>JULY 13, 1897</b>  |   | 6. AGE (In years last birthday)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>OKLAHOMA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WASH. SAN. Hosp.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)<br><b>none</b>                              |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>P.G.</b>  |   | 13c. CITY OR TOWN<br><b>BELTSVILLE</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>11508 ALLVIEW Drive</b> |  |
| 14 FATHER'S NAME First Middle Last<br><b>William STANLEY</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Salena JONES</b>                                       |   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>445-18-1060</b>  |   | 17 INFORMANT Address<br><b>Mrs Dorothy A Beard 11508 Allview Dr, Beltsville</b> |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Constrictive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>1 yr</b><br><b>undetermined</b> |  |   |   |   |   |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4</b>   |  |   |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> , to <b>Dec 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 1, 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>James W. [Signature]</b> DEGREE   |  |   |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12-2-68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>James W. [Signature]</b>  |  |   |   |   |   | 22e. ADDRESS<br><b>7717 Canall Ave Takoma Park</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Dec 3, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Creek Mem. Cemetery</b>         |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>OKlahoma City, Okla</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Takoma Funeral Home 254 Canale St NW</b>  |  |   |   |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 4 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                            |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

17006

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17947

# CERTIFICATE OF DEATH

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1 DECEASED-NAME<br>(Type or print) First Middle Last<br><b>LAWRENCE FADELY SCHILLER</b>   |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>Dec. 12 20 68</b> |  | 2b. HOUR<br><b>6 A M</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br><b>JUNE 27, 1901</b>   |   | 6. AGE (In years last birthday)<br><b>67</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VA.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH<br><b>Montgomery</b>                      |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WASH &amp; AN Hosp</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Retired. Se. RR</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |   |
| 14. FATHER'S NAME First Middle Last<br><b>LAWRENCE F. Schiller</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ophelia HARDING</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Confusion</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>718-10-5823</b>   |   | 17. INFORMANT<br><b>PATIENTS CHART</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) <b>BRAIN TUMOR, GLIOMA</b><br><b>111X</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE YEAR</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1730</b>  |   |  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>JAN 1968</b> , to <b>20 DEC 1968</b> , that (I) (we) last saw the deceased alive on <b>12/19/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |   |  |   |  |   |
| 22b. SIGNATURE<br><b>Robert H. Meudelwhe, MD</b>  |   | 22c. ADDRESS<br><b>1015 Spring St. Silver Spring Md</b>  |   | 22d. DATE SIGNED<br><b>12/20/68</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>Dec 23, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Annapolis Maryland Md</b>   |   | 24. FUNERAL DIRECTOR<br><b>Takoma Funeral Home J. A. Hatter</b>  |   |  |   |
| 25a. REC'D BY REGISTRAR<br><b>DEC 24 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17997

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17948

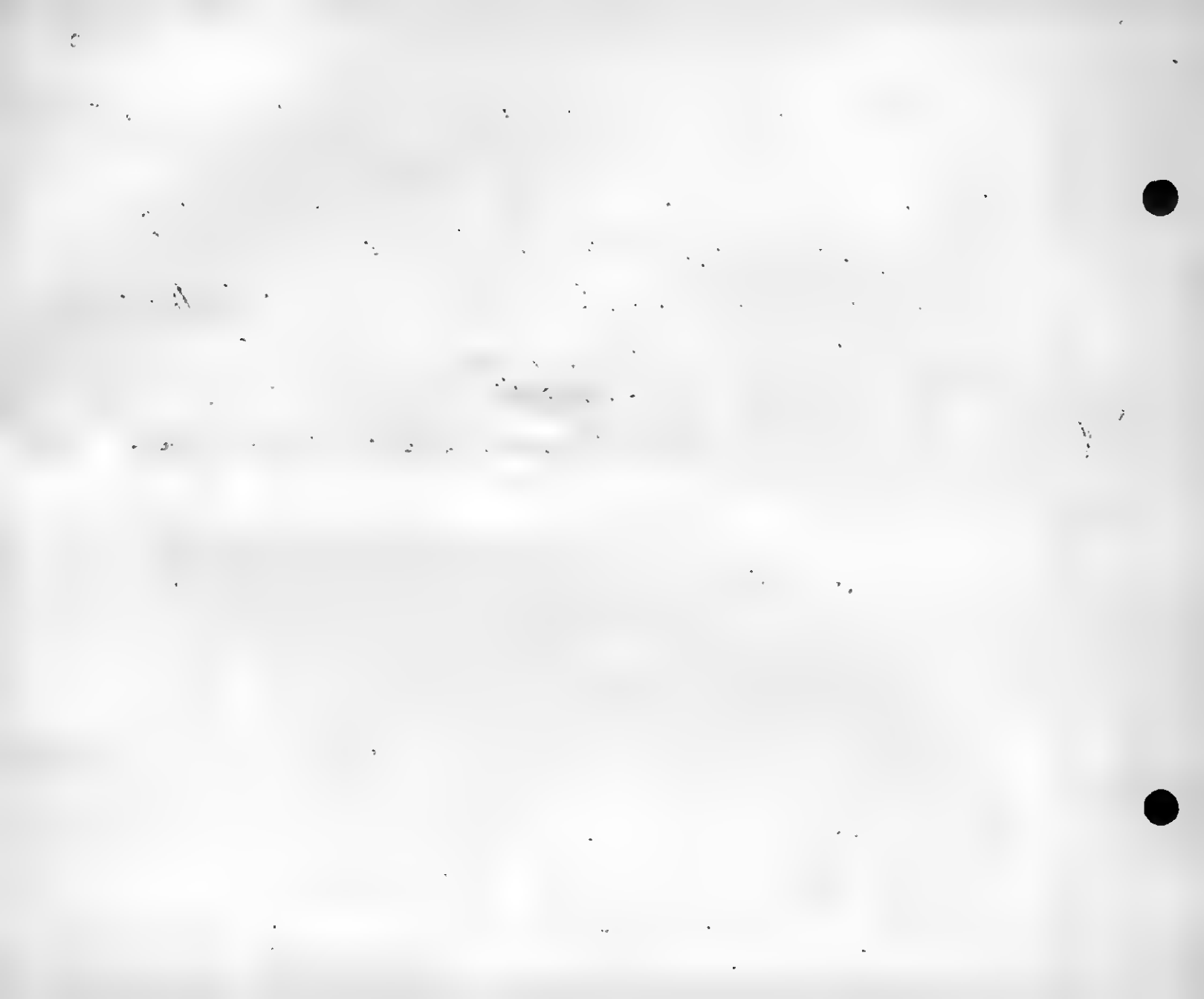
# CERTIFICATE OF DEATH

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Stella (Wm) Schmidt</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>12</b> Day <b>14</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>2:30 AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br><b>03-14-82</b>   |  | 6. AGE (In years last birthday)<br><b>86</b> YRS.                                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Lyria Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Bethesda-Silver Spring Nursing Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>3304 Shepherd St.</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>Adam Schmidt</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>JOHNNA SCHMANN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>278-22-4444</b>  |   | 16c. INFORMANT<br><b>Mrs. Betty Linsch</b>  |  | Address<br><b>3304 Shepherd St Chevy Chase</b>                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))   |  |   |   |   |  |   |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b> YRS<br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>334X</b>        |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>NECROSIS OF BONE &amp; TISSUES DUE TO DECUBITUS ULCERS</b>  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-30, 1967</b> , to <b>12-14, 1968</b> , that (I) (we) last saw the deceased alive on <b>12-14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard H. Pollen MD</b>   |  | 22c. DATE SIGNED<br><b>12/14/68</b>   |   | 22d. PHYSICIAN'S NAME (Type)<br><b>RICHARD H. POLLEN MD</b>   |  |   |  |
| 22e. ADDRESS<br><b>10400 CONNECTICUT AVE KENSINGTON, MD 20795</b>   |  |   |   |   |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12/17/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KIDGELAWN CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ELYRIA, LORAIN, OHIO</b>      |  |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH GAULDER'S SONS, INC. WASH., D.C.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 19 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |   |  |

MEDICAL CERTIFICATION

2

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17949

|   |                              |  |   |   |   |                                     |  |
|---|------------------------------|--|---|---|---|-------------------------------------|--|
| 1 DECEASED NAME<br>(Type or print)  |                              | First  | Middle  | Last  | 2a DATE OF DEATH<br>(Month)   | Year                                | 2b HOUR  |
| Gertrude  |                              | C  |   | Scrivenor   | December  | 1968                                | 7:30 PM  |
| 3 SEX   | 4 RACE                       |  | 5. DATE OF BIRTH  |   | 6 AGE (In years<br>last birthday)   | IF UNDER 1 YEAR<br>MONTHS           | IF UNDER 24 HRS.<br>DAYS HOURS MIN.                                    |
| Female  | White                        |  | Sept 21, 1879   |   | 88 89 YRS   |                                     |  |
| 7a BIRTHPLACE (State or foreign<br>country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                                     |  |
| New York  | U.S.A.                       |  |   |   | Montgomery  |                                     |  |
| 10 CITY OR TOWN OF DEATH  |                              | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital,<br>give street address)  |   | 12a USUAL OCCUPATION (Kind of work done<br>during last of working life, even if retired)                                      |   | 12b KIND OF BUSINESS OR<br>INDUSTRY |  |
| Kensington  |                              | Carroll Hall San.  |   | Housewife   |   | own home                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before<br>admission) STATE  |                              | 13b COUNTY   | 13c CITY OR TOWN  | 13a INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                | 13e STREET AND NUMBER   |                                     |  |
| Md.   |                              | Montgomery   | Kensington  |   | 3906 Knowles Avenue   |                                     |  |
| 14 FATHER'S NAME  |                              | First  | Middle  | Last  | 15 MOTHER'S MAIDEN NAME First Middle Last   |                                     |  |
| Samuel  |                              | F.   |   | Terwilliger   | Ella M. Patrick   |                                     |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |                              | 16b SOCIAL SECURITY NO.  |   | 17 INFORMANT  |   |                                     |  |
| No  |                              | 220-44-2950  |   | Mrs. Justin Farrell 3915 Baltimore Ave  |   |                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Choke asphyxia</u>  |                              |  |   |   |   |                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                        |
| 41 DUE TO, OR AS A CONSEQUENCE OF <u>Congestive heart failure</u>   |                              |  |   |   |   |                                     | 12 hrs.  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Congestive heart failure</u>   |                              |  |   |   |   |                                     | 2 wks  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Choke asphyxia</u>  |                              |  |   |   |   |                                     | 4  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br>4200   |                              |  |   |   |   |                                     |  |
| 19a DATE OF OPERATION   |                              | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                              | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)   |   |                                     |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)<br>(OFFICE, BUILDING, ETC) |   | 21f LOCATION Street or R.F.D. No City or Town County State  |   |                                     |  |
|   |                              |  |   |   |   |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11</u> , 19 <u>65</u> , to <u>Jan 25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death |                              |  |   |   |   |                                     |  |
| 22b SIGNATURE   |                              | DEGREE   |   | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |   | 22c. DATE SIGNED                    |  |
| George Sharpe, M.D.   |                              |  |   |   |   | December 25, 1968                   |  |
| 22d PHYSICIAN'S NAME (Type)   |                              | 22e ADDRESS  |   |   |   |                                     |  |
| George Sharpe, M.D.   |                              | 10400 Connecticut Avenue, Kensington, Md.  |   |   |   |                                     |  |
| 23a BURIAL, CREMATION,<br>REMOVAL (Specify)   | 23b DATE                     | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION (City or Town) (County) (State)  |   |                                     |  |
| Burial  | 12-30-1968                   | Arlington National Cem.  |   | Arlington, Virginia   |   |                                     |  |
| 24 FUNERAL DIRECTOR   |                              | ADDRESS  |   | 25a REC'D BY REGISTRAR  |   | 25b REGISTRAR'S SIGNATURE           |  |
| J. W. Lee   |                              | Sil. Spr., Md.   |   | JAN 3 1969  |   | Charles Judge                       |  |
| Warner E. Purphrey, Inc. 8434 Georgia Avenue  |                              |  |   |   |   |                                     |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |                               |  |  |
|---|--|--|--|--|--|--|--|--|-------------------------------|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |                               |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Edward J. Scroggins</b>  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br><b>Dec. 1 1968</b>   |  |  | 2b. HOUR<br><b>12:50 P.M.</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>21 June 1931</b>  |  | 6. AGE (In years lost birthday)<br><b>37</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS  |                               | IF UNDER 24 HRS. HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Mont. Co.</b> Md.   |  |  |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sil. Spg. Md.</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>Holy Cross Hosp.</b>  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Asbestos Worker</b> |                               |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hair Engr.</b>  |  |  |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Mont. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>  |                               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>507 Castleford Dr</b>  |  |  |  | 14. FATHER'S NAME First Middle Last<br><b>EDWARD J. SCROGGINS</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>NAOMA GRIFFITH</b>  |  |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO<br><b>UNKNOWN</b>  |  | 17. INFORMANT Address<br><b>JUNEM SCROGGINS WIFE SILVER SPRING MD</b>  |  |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |                               |  |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary arrest</b>  |  |  |  |  |  |  |  |  |                               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Uremia</b>  |  |  |  |  |  |  |  |  |                               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Inoperant Hypertension &amp; Atherosclerosis</b>  |  |  |  |  |  |  |  |  |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Coronary Heart Failure</b>  |  |  |  |  |  |  |  |  |                               |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                               |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |  | 21f. LOCATION Street or R.F.D. No  |  | City or Town   |  | County   |                               | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 13</b> , 1968, to <b>Dec 1</b> , 1968, that (I) (we) last saw the deceased alive on <b>November 30</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |                               |  |  |
| 22b. SIGNATURE<br><b>Harold W. Draper M.D.</b> DEGREE   |  |  |  |  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Dec 1, 1968</b>   |                               |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>HAROLD W. DRAPER M.D.</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>9801 GEORGIA AVE, Silver Spring</b>   |  |  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL Specify<br><b>BURIAL</b>  |  | 23b. DATE<br><b>12-4-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Francis Cemetery</b>  |  | 23d. LOCATION (City or Town)<br><b>Bladensburg</b>   |  | County<br><b>MD.</b>   |                               | State  |  |
| 24. FUNERAL DIRECTOR<br><b>W. H. Chambers</b>   |  | ADDRESS<br><b>1400 Chapin Rd</b>   |  | 25a. RECD BY REGISTRAR<br><b>DEC 3 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jones</b>  |  |  |                               |  |  |



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VR A15  
30M REV. 1-58

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                         |  |  |  |  |   |                   |
|--|--|--|-------------------------|--|--|--|--|---|-------------------|
| CERTIFICATE OF DEATH   |  |  |                         |  |  |  |  |   |                   |
| 17951  |  |  |                         |  |  |  |  |   |                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                   | Middle   | Last   | 2a. DATE OF DEATH  |  |   | 2b. HOUR          |
| WILLIAM  |  |  | HENRY                   | SEAQUIST   | Month 12 Day 25 Year 68  |  |  | 8:21 P  |                   |
| 3. SEX   |  | 4. RACE  |                         | 5. DATE OF BIRTH   |  | 6 AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                |                   |
| Male   |  | Caucasian  |                         | 10-15-93   |  | 75 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                |                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                         | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |                   |
| Maryland   |  | United States  |                         |  |  | Montgomery Md.   |  |   |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                         | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |                   |
| Olney  |  | Montgomery General Hospital  |                         | Retired mechanical Engr.   |  | Gov't.   |  |   |                   |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE  |  | 13b. COUNTY  |                         | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |                   |
| Maryland   |  | Montgomery   |                         | Olney  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | Sharon Nursing Home<br>18201 Marden Lane                      |                   |
| 14 FATHER'S NAME   |  |  | First                   | Middle   | Last   | 15 MOTHER'S MAIDEN NAME  |  |   | First Middle Last |
| Andrew   |  |  |                         |  | Sequist  | Hannah   |  |   | Johnson           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO |  |  | 17 INFORMANT   |  |   |                   |
| no   |  |  |                         |  |  | Admission Recd., Montgomery Gen. Hospital, Olney, Md.  |  |   |                   |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD &amp; aortic insuff. and angina pectoris 5 yrs.</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) stating the underlying cause lost: <u>4201</u><br>(c)   |  |  |                         |  |  |  |  | APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH<br><u>1 hr.</u> |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Carcinoma of prostate</u>  |  |  |                         |  |  |  |  |   |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |  |   |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                         |  | 21f. LOCATION Street or R.F.D. No City or Town County State                          |  |  |   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>Dec. 25, 1968</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12-10-1968</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death. |  |  |                         |  |  |  |  |   |                   |
| 22b. SIGNATURE<br><u>Frederick Moomau M.D.</u>   |  |  |                         |  | 22c. DATE SIGNED<br><u>12-25-68</u>  |  | 22d. ADDRESS   |   |                   |
| 22d. PHYSICIAN S NAME (Type)<br>Frederick Moomau, M.D.   |  |  |                         |  | 22e. ADDRESS   |  |  |   |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><u>12-28-68</u>   |                         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland Md.</u>                         |  |   |                   |
| 24. FUNERAL DIRECTOR<br><u>Ernest C. Galtner</u>   |  |  |                         |  | 25a. REC'D BY REGISTRAR<br><u>DEC 30 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |   |                   |



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VR A15  
30M REV 1-68

17911

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

17952

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(Type or print) <b>Robert J. Seas</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>12</b> Day <b>4</b> Year <b>68</b> |   |  | 2b. HOUR <b>6:30</b> PM  |  |   |  |
| 3 SEX <b>male</b>   |  | 4 RACE <b>white</b>   |  | 5. DATE OF BIRTH<br><b>8/24/1906</b>  |  | 6 AGE (In years last birthday) <b>62</b> YRS.  |  | IF UNDER YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.      |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH <b>Montgomery Prince-Georges Md</b>  |  |   |  |
| 10 CITY OR TOWN OF DEATH <b>Silver Adelphia Spring</b>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Home Colonial Villa Nursing Exec. C.I.F.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Finance Co.</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Prince Adelphi</b>   |  | 13c. CITY OR TOWN <b>Adelphi</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET AND NUMBER <b>1818 Metzert Rd.</b>                |  |
| 14. FATHER'S NAME First Middle Last <b>unobtainable</b>   |  |   | 15. MOTHER'S M.A.DEN NAME First Middle Last <b>unobtainable</b>  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>284-10-0559</b>   |  | 17. INFORMANT Address <b>Mrs. Robert Seas (same as above)</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral negative septicaemia</b><br><b>5170</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Urinary tract infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Long Parkinson's disease</b>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1968</b> to <b>Dec 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Benne G. Bendler M.D.</b> DEGREE  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED <b>12/4/68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Benne G. Bendler, M.D.</b>  |  |   |  | 22e. ADDRESS <b>4511 W.Va. Avenue-Bethesda, Md.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>12/7/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>The S.H.Hines Co. Washington, D.C.</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>DEC 7 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>W. J. Judge</b>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Miriam</i>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <i>December</i> Day <i>20</i> Year <i>1968</i>   |  |  | 2b. HOUR<br><i>11:30 p.m.</i>  |  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>White</i>  |  |  | 5. DATE OF BIRTH<br><i>September 12, 1893</i>   |  |  | 6. AGE (In years last birthday)<br><i>75</i> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Russia</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Montgomery County Silver Spring</i> Md.                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Holy Cross Hosp. Tol of Silver Spring</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>(Housewife) Cashier</i>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i>                                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><i>Maryland</i>  |  |  | 13b. COUNTY<br><i>Montgomery</i>   |  |  | 13c. CITY OR TOWN<br><i>Rockville</i>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><i>13000 PACIFIC AVENUE</i>   |  |  | 14. FATHER'S NAME<br>First <i>JACOB</i> Middle <i>Katz</i> Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Brina</i> Middle Last  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><i>Mildred H. LEFF - 7509 Polce Drive</i>  |  |  | Address<br><i>Annapolis, Virginia</i>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute left ventricular failure</i><br><i>4/1/1</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4/1/1</i> |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 hours</i><br><i>years</i>               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Diabetes mellitus; arteriosclerotic renal disease</i>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May, 1958</i> , to <i>12-20, 1968</i> , that (I) (we) last saw the deceased alive on <i>12-20, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Jason Gerber, M.D.</i>   |  |  | DEGREE<br><i>M.D.</i>  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><i>12-20-68</i>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>JASON GERBER, M.D.</i>   |  |  | 22e. ADDRESS<br><i>810 PERSHING DRIVE SILVER SPRING, MD.</i>   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>12-22-68</i>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Bnai Israel Cemetery</i>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Norfolk, Virginia</i>                    |  |  |
| 24. FUNERAL DIRECTOR<br><i>Bernard Danzansky &amp; Sons</i>   |  |  | ADDRESS<br><i>3501 14th Street, N.W. Washington, D.C. 20010</i>  |  |  | 25a. REC'D BY REGISTRAR<br><i>DEC 26 1968</i>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pags 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MONTGOMERY STATE DEPARTMENT OF HEALTH   |         |  |  |   |      |  |  |                                   |  |
|---|---------|--|--|---|------|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |      |  |  |                                   |  |
| CERTIFICATE OF DEATH  |         |  |  |   |      |  |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First  | Middle  | Last | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR P                        |  |
| Lawrence Ellsworth Shinn  |         |  |  |   |      | December 11 1968   |  | 5:30 PM                           |  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH   |   |      | 6. AGE (In years last birthday)  |  | 7. IF UNDER 1 YEAR                |  |
| Male  | White   |  | 11/19/10   |   |      | 58 YRS   |  | MONTHS DAYS HOURS MIN             |  |
| 7a. BIRTHPLACE (State or foreign country)   |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                |  |
| Ohio  |         |  | U.S.A.   |   |      |  |  | Montgomery Md                     |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Olney   |         |  | Montgomery General   |   |      | Bacteriologist   |  | Gov't.                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution)   |         |  | 13b. CITY OR TOWN  |   |      | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER            |  |
| Maryland  |         |  | Howard   |   |      | Clarksville  |  | Clarksville Ridge                 |  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |   |      |  |  |                                   |  |
| Charles W. Shinn  |         |  | Mabel Ellsworth  |   |      |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown?  |         |  | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT  |  |                                   |  |
| yes   |         |  | 216-44-7734  |   |      | records Address  |  |                                   |  |
|   |         |  |  |   |      | Montgomery General Hospital, Olney, Md.  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |         |  |  |   |      |  |  |                                   |  |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>1539</u> <u>hours</u>   |         |  |  |   |      |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post Operative Laparotomy &amp; Colostomy</u> <u>1 week</u>   |         |  |  |   |      |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intestinal Obstruction 2<sup>nd</sup> Carcinoma</u> <u>4 weeks</u>  |         |  |  |   |      |  |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Peritonitis, acute</u>  |         |  |  |   |      |  |  |                                   |  |
| 19a. DATE OF OPERAT ON  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  | 20a. AUTOPSY?   |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |                                   |  |
| 12-4-68   |         | Intestinal Obstruction   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      | Yes  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18.) |      |  |  |                                   |  |
|   |         | HOUR A.M. Month Day Year   |  |   |      |  |  |                                   |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC |  | 21f. LOCATION   |      |  |  |                                   |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |         |  |  | Street or R.F.D. No City or Town County State                         |      |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>68</u> , to <u>12/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |  |   |      |  |  |                                   |  |
| 22b. SIGNATURE  |         |  |  | 22c. DATE SIGNED  |      |  |  |                                   |  |
| <u>Charles S. Whitaker, M.D.</u>  |         |  |  | <u>12/13/68</u>   |      |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |         |  |  | 22e. ADDRESS  |      |  |  |                                   |  |
| Charles S. Whitaker, M. D.  |         |  |  | Clarksville, Maryland   |      |  |  |                                   |  |
| 23a. BURIAL CREMATION   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                    |      | 23d. LOCATION (City or Town)   |  | 23e. REGISTRAR'S SIGNATURE        |  |
| <u>Cremation</u>  |         | <u>11-13-68</u>  |  | <u>Lee Funeral Home</u>   |      | <u>Washington</u>  |  | <u>D.C.</u>                       |  |
| 24. FUNERAL DIRECTOR  |         |  |  | 25a. REC'D BY REGISTRAR   |      | 25b. REGISTRAR'S SIGNATURE   |  |                                   |  |
| <u>Hughston - Slack</u>   |         |  |  | <u>DEC 16 1968</u>  |      | <u>Charles Judge</u>   |  |                                   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |                              |  |   |                                    |  |                         |  |                                   | 17955  |  |
|--|--------|------------------------------|--|---|------------------------------------|--|-------------------------|--|-----------------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| 1 DECEASED NAME<br>(Type or Print)   |        |                              | First Middle Last  |   |                                    | 2a. DATE KNOWN OF DEATH  |                         |  | 2b. HOUR                          |  |  |
| James Theodore Simms   |        |                              |  |   |                                    | Month Day Year   |                         |  | 6 12 M                            |  |  |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH              | 6 AGE (In years last birthday)   | IF UNDER 1 YEAR   |                                    | IF UNDER 24 HRS  |                         | 2c. DATE PRONOUNCED DEAD   |                                   | 2d. HOUR                                     |  |
| M.   | Negro  | Nov. 25, 1925                | 43 YRS   | MONTHS  | DAYS                               | HOURS  | MIN                     | Month Day Year   | 6 26 M                            |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |        | 7b. CITIZEN OF WHAT COUNTRY? |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |                         |  |                                   |  |  |
| Virginia   |        | U.S.A.                       |  |   |                                    | Montgomery Md.   |                         |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |        |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                         |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Bethesda   |        |                              | Suburban   |   |                                    | Truck Driver   |                         |  | Hauling.                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if at institution. Residence before admission) STATE   |        |                              | 13b. COUNTY  |   |                                    | 13c. CITY OR TOWN  |                         |  | 13e. STREET AND NUMBER            |  |  |
| Md.  |        |                              | Montgomery   |   |                                    | Rockville  |                         |  | 303 N. Adams St.                  |  |  |
| 4 FATHER'S NAME  |        |                              | 5 MOTHER'S MAIDEN NAME   |   |                                    |  |                         |  |                                   |  |  |
| John S Simms   |        |                              | Gertrude Newmar  |   |                                    |  |                         |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |        |                              | 16b. SOCIAL SECURITY NO  |   |                                    | 17 INFORMANT   |                         |  | ADDRESS                           |  |  |
| Yes  |        |                              | 1942-46  |   |                                    | Brother  |                         |  | Rt 2. Knoxville                   |  |  |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))   |        |                              |  |   |                                    |  |                         |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction Acute  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |        |                              |  |   |                                    |  |                         |  |                                   | years  |  |
| (b) Cardio Vascular Disease  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| (c)  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| Fatty Metamorphosis of Liver   |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| 19a. DATE OF OPERATION   |        |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                    |  |                         | 20. AUTOPSY?   |                                   |  |  |
|  |        |                              |  |   |                                    |  |                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |        |                              |  | 21b. TIME OF INJURY Month, Day, Year  |                                    |  |                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |                                   |  |  |
|  |        |                              |  | P.M. 19   |                                    |  |                         |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |        |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |                                    |  |                         | 21f. LOCATION Street or R.F.D. No City or Town County State                    |                                   |  |  |
|  |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        |                              |  |   |                                    |  |                         |  |                                   |  |  |
| ACTUAL SIGNATURE   |        |                              |  | CHIEF MEDICAL EXAMINER  |                                    |  |                         | 22b. DATE SIGNED   |                                   |  |  |
| EXAMINER'S NAME (Type)   |        |                              |  | ASSISTANT MEDICAL EXAMINER  |                                    |  |                         | Dec. 15, 1968  |                                   |  |  |
|  |        |                              |  | DEPUTY MEDICAL EXAMINER   |                                    |  |                         |  |                                   |  |  |
|  |        |                              |  | ADDRESS (Street, city, town, or county)   |                                    |  |                         |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |        |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |                         | 23d. LOCATION (City or Town) (County) (State)                                  |                                   |  |  |
| REMOVAL  |        |                              | 12-17-68   |   | BROWN FUNERAL HOME                 |  |                         | LOVETTSVILLE VA  |                                   |  |  |
| 24. FUNERAL DIRECTOR   |        |                              |  |   | ADDRESS                            |  | 25a. REC'D BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE        |  |  |
| ROBERT L. SNOWDEN  |        |                              |  |   | ROCKVILLE, MARYLAND                |  | DEC 20 1968             |  | Charles Judge                     |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 17956  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 1. DECEASED NAME<br>(Type or print)  |  |  | First<br>MARY  |  |  | Middle<br>LEIS  |  |  | Last<br>SMITH   |  |  | 2a. DATE OF DEATH<br>Month<br>12<br>Day<br>5<br>Year<br>68    |  |  | 2b. HOUR<br>2:04 PM             |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>January 27, 1908  |  |  | 6. AGE (In years<br>last birthday)<br>60 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                             |  |  | IF UNDER 24 HRS<br>HOURS<br>MIN |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Missouri   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Montgomery  |  |  | Md.   |  |  |                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>13490 Old Columbia Pike |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>Clerk  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>U.S. Army   |  |  |   |  |  |                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before<br>admission) STATE<br>Missouri  |  |  | 13b. COUNTY<br>Miller  |  |  | 13c. CITY OR TOWN<br>Sherris  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>Star Route                          |  |  |                                 |  |  |
| 14. FATHER'S NAME<br>First<br>Wenden   |  |  | Middle<br>Arthur   |  |  | Last<br>Petree  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Bernice  |  |  | Middle<br>Henry   |  |  | Last<br>Petree                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>no  |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>491-09-7054   |  |  | 17. INFORMANT<br>Pan Petree   |  |  | Address<br>13490 Old Columbia Pike<br>Silver Spring, Maryland |  |  |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |  |  |                                 |  |  |
| PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS &amp; METASTASES</u>   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 157.4  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| (b)  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| (c)  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 157X   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |  |   |  |  |   |  |  |                                 |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |  |  |   |  |  |   |  |  |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>Dec 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 22b. SIGNATURE<br><u>Bernard A. Fitzgerald</u>   |  |  | DEGREE<br>M.D.   |  |  | ATTENDING<br>PHYS <input checked="" type="checkbox"/> MED<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS <input type="checkbox"/>                       |  |  | 22c. DATE SIGNED<br>12-5-68   |  |  |   |  |  |                                 |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>BERNARD A. FITZGERALD   |  |  | 22e. ADDRESS<br>217 UNIV. BLVD E, SILVER SPRING Md   |  |  |   |  |  |   |  |  |   |  |  |                                 |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>Mar. 8, 1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bethany Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Pulaski County, Missouri                       |  |  |   |  |  |                                 |  |  |
| 24. FUNERAL DIRECTOR<br><u>Arthur Walters</u>  |  |  | ADDRESS<br>254 Canal Street Wash. D.C.   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>DEC 9 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>McIntosh Judge</u>   |  |  |   |  |  |                                 |  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 408 MARYLAND STATE DEPARTMENT OF HEALTH  
1-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17936

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17957

|  |                        |   |   |  |  |   |  |
|--|------------------------|---|---|--|--|---|--|
| 1 DECEASED NAME<br>(Type or Print) <b>Garland</b>  |                        | First <b>Garland</b> Middle <b>XXXXXX</b> Last <b>XXXXXX</b>  |   | 2a. DATE KNOWN OF DEATH<br>Month <b>12</b> Day <b>18</b> Year <b>1968</b>  |  | 2b. HOUR <b>M</b>   |  |
| 3 SEX<br><b>female</b>   | 4 RACE<br><b>white</b> | 5 DATE OF BIRTH<br><b>May 14, 1918</b>  | 6 AGE (in years last birthday)<br><b>50</b> YRS | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>   | 2c. DATE PRONOUNCED DEAD<br>Month <b>Dec</b> Day <b>18</b> Year <b>68</b>           |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |                        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>9016 Walden Rd. C.G. Md.</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>housewife</b>                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>  |                        | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Silver Spring</b>       | 3d. INSIDE CITY, YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>9016 Walden Rd.</b> |   |  |
| 14. FATHER'S NAME<br>First <b>George</b> Middle <b>W.</b> Last <b>Garland</b>  |                        | 15. MOTHER'S MAIDEN NAME<br>First <b>Louise</b> Middle <b>--</b> Last <b>Brown</b>  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                        | 16b. SOCIAL SECURITY NO<br>(If yes give year or dates of service) <b>578-09-5057</b>  |   | 17. INFORMANT <b>Jurinus L. Snoddy</b> ADDRESS <b>Maryland</b>   |  |   |  |
|  |                        |   |   | ADDRESS <b>9016 Walden Road Sil Spr</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute lobar pneumonia,</b><br><b>481x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>upper lobe, right lung</b><br>(b) <b>upper lobe, right lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                 |                        |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>49</b>   |                        |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                        | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                        | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |   | 21f. LOCATION Street or RFD No. City or Town County State  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |   |   |  |  |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>   |                        | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>DEC. 18, 1968</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                        | 23b. DATE <b>12-21-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sedar Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince Georges, Maryland</b>    |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>  |                        |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Yunge</b>                                  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and upon event, within 72 hours after death.

VR A15 (4)  
45M - 1-68

|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 17017   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 17958  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Dora E. Snyder  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>Dec 8 1968  |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>10 A.M.                          |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3 SEX<br>Female   |  |  |  |  | 4. RACE<br>Caucasian   |  |  |  |  | 5. DATE OF BIRTH<br>April 11, 1884  |  |  |  |  | 6 AGE (In years last birthday)<br>84 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Nebraska   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                        |  |  |  |  | 9. COUNTY OF DEATH<br>Montgomery Md.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>10014 Bentzen Road |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Housewife   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE<br>Md.  |  |  |  |  | 13b. COUNTY<br>Montgomery  |  |  |  |  | 13c. CITY OR TOWN<br>Silver Sp.   |  |  |  |  | 13d. INSIDE CITY, APTS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>10014 Bentzen Road |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Mark Prime   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Alice Freed  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (I say give war or dates of service)<br>No   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO<br>508-26-0028       |  |  |  |  | 17 INFORMANT<br>Miss Harriet L. Snyder 10014 Bentzen Rd. Silver Spring, Md. |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Minor Stroke and Cardiac Failure.</u><br>+579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral + Cardiac arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 hours.<br>24 hours.<br>20+ years  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>334X   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                           |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC)                      |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from April 25, 1968, to Dec 8, 1968, that (I) (we) last saw the deceased alive on Dec 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>R. Stephen Hulburt, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>Dec 9, 1968              |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>R. Stephen Hulburt  |  |  |  |  | 22e. ADDRESS<br>3000 Dent Place, N. W., Wash., D. C.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>Dec 10 1968   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rock Creek Cemetery   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Washington, D. C.                             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>C. Glen Carter, 4341 Georgia Ave.<br>Warner C. Pumphrey, Inc. Silver Spring, Md.  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DEC 12 1968   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |  |                              |   |   |   |   |  |
|---|--|---|---|--|------------------------------|---|---|---|---|--|
| Item 23 Film G408 1/6/69 kk   |  |   |   | CERTIFICATE OF DEATH   |                              |   |   | 17959   |   |  |
| 1 DECEASED-NAME<br>(Type or print) First Middle Last<br>Dewey Miles Sparks  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>DEC. 24 1968                                     |  |                              | 2b. HOUR<br>3:50 A.M.   |   |   |   |  |
| 3 SEX<br>Male   |  | 4. RACE<br>White  |   | 5 DATE OF BIRTH<br>Jan 22, 1905  |                              | 6 AGE (In years lost birth day)<br>63 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |   |  |
| 7a BIRTHPLACE (State or foreign country)<br>S.C.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9 COUNTY OF DEATH<br>Montgomery Md.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |   | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br>Suburban |  |                              | 12a USUA. OCCUPATION (Kind of work done during most of working life even if retired.)<br>Meat Cutter                                |   |   | 12b KIND OF BUSINESS OR INDUSTRY              |  |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE<br>Md.   |  |   | 13b COUNTY<br>Montgomery  |  | 13c CITY OR TOWN<br>Bethesda |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET AND NUMBER<br>6415 Camrose Terrace |  |
| 14. FATHER'S NAME First Middle Last<br>George W. Sparks   |  |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Minnie Cash  |                              |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN (If yes give war or dates of service)  |  |   |   | 16b SOCIAL SECURITY NO<br>577 09 4843  |                              | 17 INFORMANT Address<br>George Sparks 795 Princeton Pl. Rockville, Md.  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cerebral Infarction<br>4330<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cerebral Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis |  |   |   |  |                              |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 DAYS<br>7 YEARS<br>7 YEARS  |   |  |
|   |  |   |   |  |                              |   |   | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>HYPERTENSION, ESSENTIAL |   |  |
|   |  |   |   |  |                              |   |   | 19a DATE OF OPERATION   |   |  |
|   |  |   |   |  |                              |   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |
| 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES     |   |  |                              |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |                              |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc) |   | 21f LOCATION Street or R.F.D. No. City or Town County State  |                              |   |   |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from April 21, 1953, to Dec. 24, 1968, that (I) (we) saw the deceased alive on Dec. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                              |   |   |   |   |  |
| 22b SIGNATURE<br>Robert G. Angle M.D.   |  |   |   |  |                              | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |   | 22c DATE SIGNED<br>DEC. 24, 1968  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>ROBERT G. ANGLE MD.   |  |   |   |  |                              | 22e ADDRESS<br>6009 DELRAY AVE BETHESDA Md.   |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Type)   |  | 23b DATE<br>12/27/68  |   | 23c NAME OF CEMETERY OR CREMATORY<br>Oakland Cemetery  |                              | 23d LOCATION (City or Town) (County) (State)<br>Gaffney South Carolina  |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>Tyson Wheeler F.H. 1331 Rockville Pike Rockville, Maryland  |  |   |   | 25a REC'D BY REGISTRAR<br>DEC 27 1968  |                              | 25b REGISTRAR'S SIGNATURE<br>Charles Judge  |   |   |   |  |

MEDICAL CERTIFICATION



47-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH  |        |  |  |  |                                   |  |  |   |   |
|--|--------|--|--|--|-----------------------------------|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |  |  |  |                                   |  |  |   |   |
| CERTIFICATE OF DEATH   |        |  |  |  |                                   |  |  |   |   |
| 17960  |        |  |  |  |                                   |  |  |   |   |
| 1 DECEASED-NAME<br>(Type or print)   |        |  | First Middle Last  |  |                                   | 2a DATE OF DEATH<br>Month Day Year   |  |   | 2b HOUR   |
| Ralph J. Sprague   |        |  |  |  |                                   | Dec 27 1968  |  |   | 1:10 AM   |
| 3 SEX  | 4 RACE |  | 5 DATE OF BIRTH  |  |                                   | 6 AGE (in years<br>lost birthday)  |  | 7 UNDER YEAR<br>MONTHS DAYS HOURS MIN                                   |   |
| male   | white  |  | 1-4-1898   |  |                                   | 70   |  |   |   |
| 7a BIRTHPLACE (State or foreign<br>country)  |        |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH   |   |
| Wisconsin  |        |  | USA  |  |                                   |  |  | Montgomery  |   |
| 10 CITY OR TOWN OF DEATH   |        |  | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital<br>give street address) |  |                                   | 12a USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)   |  | 12b KIND OF BUSINESS OR<br>INDUSTRY                                     |   |
| Bethesda   |        |  | Suburban   |  |                                   | Retired  |  | Gov't   |   |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institut on<br>admission) STATE   |        |  | 13b COUNTY   |  | 13c CITY OR TOWN                  |  | 13d INSIDE CITY, Y, N, TSP<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 3e STREET AND NUMBER                            |
| md   |        |  | Montgomery   |  | Bethesda                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   | 9019 Lindale Drive                              |
| 14. FATHER'S NAME<br>First Middle Last   |        |  | 15 MOTHER'S MAIDEN NAME First Middle Last                                      |  |                                   |  |  |   |   |
| Frank Sprague  |        |  | Mabel DeWitt   |  |                                   |  |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |        |  | 16b SOCIAL SECURITY NO.  |  |                                   | 17 INFORMANT   |  | Address   |   |
| Yes  |        |  | VW I   |  |                                   | wife   |  | Same as Item 13.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |        |  |  |  |                                   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)  |        |  | Cerebro-vascular accident  |  |                                   |  |  |   | 1 day   |
| 4369   |        |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                                   |  |  |   |   |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |        |  | (b) arteriosclerosis   |  |                                   |  |  |   |   |
| 337X   |        |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                                   |  |  |   |   |
| (c)  |        |  |  |  |                                   |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |        |  |  |  |                                   |  |  |   |   |
| Emphysema, congestive heart failure, renal insufficiency, pneumonia  |        |  |  |  |                                   |  |  |   |   |
| 19a. DATE OF OPERATION   |        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |                                   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |
|  |        |  |  |  |                                   |  |  |   |   |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |        |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                     |  |                                   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |   |   |
|  |        |  |  |  |                                   |  |  |   |   |
| 21a INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC) |  |                                   | 21f LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
|  |        |  |  |  |                                   |  |  |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from 12/18, 1968, to 12/27, 1968, that (I) (we) last<br>saw the deceased alive on 12/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death |        |  |  |  |                                   |  |  |   |   |
| 22b SIGNATURE  |        |  |  |  |                                   |  |  |   |   |
| Allen J. O'Neill M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>  |        |  |  |  |                                   |  |  |   |   |
| 22d PHYSICIAN'S NAME (Type) Allen J. O'Neill 22e ADDRESS 8601 Old Georgetown Road, Bethesda, Md  |        |  |  |  |                                   |  |  |   |   |
| 23a BURIAL, CREMATION,<br>REMOVAL (Specify)  |        |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY |  | 23d LOCATION (City or Town) (County) (State)   |   |   |
| Burial   |        |  | 12-30-68   |  | Parklawn Cemetery                 |  | Rockville, Maryland  |   |   |
| 24 FUNERAL DIRECTOR  |        |  | ADDRESS  |  |                                   | 25a REC'D BY REG STRAR   |  | 25b REGISTRAR'S SIGNATURE   |   |
| ROBERT A. PUMPHREY, Bethesda, Maryland   |        |  |  |  |                                   | JAN 2 1969   |  | Charles Judge   |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17950

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17961

|  |  |   |  |   |  |   |   |            |  |
|--|--|---|--|---|--|---|---|------------|--|
| 1 DECEASED NAME<br>(Type or Print)   |  | First   | Middle   | Last                                    | 2a DATE KNOWN OF DEATH   | Month   | Day   | Year       | 2b HOUR                                      |
| Paul Douglas Stokes  |  |   |  |   | Dec 30   |   |   | 1968       | 5:30 PM                                      |
| 3 SEX  | 4 RACE   | 5 DATE OF BIRTH   | 6 AGE (in years last birthday)   | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN | 8 DATE PRONOUNCED DEAD   | Month   | Day   | Year       | 2d HOUR                                      |
| M  | W  | May 14 1946   | 22 YRS   |   | Dec 30   |   |   | 1968       | 5:30 PM                                      |
| 7a BIRTHPLACE (State or foreign country)   | 7b CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH   |   |  |   |   |            |  |
| Wash. DC   | U.S.A.   |   | Montgomery Md  |   |  |   |   |            |  |
| 10. CITY OR TOWN OF DEATH  | 1 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)       |   | 12b KIND OF BUSINESS OR INDUSTRY   |   |   |            |  |
| Derwood  | 19713 Muncaster Rd   |   | Student  |   |  |   |   |            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE  | 13b COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3e STREET AND NUMBER                    |  |   |   |            |  |
| Maryland   | Montgomery   | Derwood   |  | 19713 Muncaster Rd                      |  |   |   |            |  |
| 14 FATHER'S NAME   | First  | Middle  | Last   | 15 MOTHER'S M.A.D.E.N. NAME             | First  | Middle  | Last  |            |  |
| Ralph  |  | Gordon  | Stokes   | Dorothy                                 |  | May   | Young   |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   | 16b SOCIAL SECURITY NO   |   | 17 INFORMANT   |   | ADDRESS  |   |   |            |  |
| no   | 217-46-8896  |   | Father   |   | Same as 11   |   |   |            |  |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))   |  |   |  |   |  |   |   |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of Head.  |  |   |  |   |  |   |   |            | Sudden                                       |
| 955 X  |  |   |  |   |  |   |   |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |   |  |   |   |            |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |            |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |   |            |  |
| 76   |  |   |  |   |  |   |   |            |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |            |  |
|  |  |   |  |   |  |   |   |            |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |   | 21b. TIME OF INJURY Month, Day Year  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |   |   |            |  |
|  |  |   | 5:30 P.M. 12/30 1968   |   | Shot self in head with Pistol  |   |   |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)   |  | 21f. LOCATION Street or R.F.D. No       |  | City or Town                                  |   | County     |  |
|  |  | Home  |  | 19713 Muncaster Rd.                     |  | Derwood                                       |   | Montgomery |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |   |            |  |
| ACTUAL SIGNATURE   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED                              |   |            |  |
| EXAMINER'S NAME (Type)   |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |   |   |            |  |
| John G. Ball   |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |   |  | Dec 30 1968                                   |   |            |  |
|  |  |   | ADDRESS (Street, city, town, or county)  |   |  |   |   |            |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY      |  | 23d. LOCATION (City or Town) (County) (State) |   |            |  |
| Burial   |  | Jan. 2, 1968  |  | Laytonsville                            |  | Laytonsville Mont. Md.                        |   |            |  |
| 24. FUNERAL DIRECTOR   |  |   |  |   | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |            | 25b. REGISTRAR'S SIGNATURE                   |
| Francis H. Barber  |  |   |  |   | Laytonsville, Md.  |   | DATE JAN 6 1969   |            | John G. Ball                                 |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on both sides, and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

17051

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17962

|   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME<br>(Type or print) <b>STONE</b>   |  |  | First Middle Last <b>Baby Boy</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>12</b> Day <b>22</b> Year <b>68</b>  |  |  | 2b. HOUR<br><b>8:22 PM</b>   |  |  |
| 3 SEX<br><b>Male</b>  |  |  | 4 RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>Dec 22, 1968</b>  |  |  | 6. AGE (In years last birthday)<br>YRS. MONTHS DAYS <b>1</b> YRS. <b>54</b>                  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. San + Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>PG-</b>  |  |  | 13c. CITY OR TOWN<br><b>Landover</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>1817 Columbia Ave</b>  |  |  | 14 FATHER'S NAME<br>First Middle Last <b>Thomas Stone</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last <b>Judy Woody</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17 INFORMANT<br><b>PATIENTS CHART</b>  |  |  | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory + Cardiac a/c.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Prematurity</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr 54 min</b>                           |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>173.2</b>  |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 22, 1968</b> to <b>Dec 22, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Dec 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William Bryan, M.D.</b>  |  |  |   |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                     |  |  | 22c. DATE SIGNED<br><b>Dec. 22, 1968.</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>W. Bryan, M.D.</b>   |  |  |   |  |  | 22e. ADDRESS<br><b>7600 Carroll Ave, Takoma Park, Maryland</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>12-24-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington San. &amp; Hospital</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>7600 Carroll T.P. Mont. Md.</b>          |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>J.D. Ruffcorn 7600 Carroll Ave. T, P. Md.</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 27 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |  |   |   |
|---|--|--|--|---|---|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |   |   |
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |   |   |
| Baby Girl Stone   |  |  |  |   | Month 12 Day 23 Year 68   |  | 8:25 AM  |   |   |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |   | 6 AGE (in years<br>lost birthday)  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |   |
| Female  |  | White  |  | Dec 22, 1968  |   | — YRS.   |  | 3 5 45                                      |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |   |
| Maryland  |  | USA  |  |   |   | Montgomery Md.   |  |   |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,<br>give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY        |   |
| Takoma Park   |  |  | Wash San + Hosp.   |   |   |  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before<br>admission) STATE  |  |  | 13b. CITY OR TOWN  |   | 13c. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |   |   |
| Maryland  |  |  | P.G. Landover  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1876 Columbia Ave  |   |   |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |  |  |   |   |
| Thomas Stone  |  |  | Judy Woody   |   |   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  | Address  |   |   |
| No  |  |  |  |   | PATIENTS chart  |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory + Cardiac Failure</u>  |  |  |  |   |   |  |  |   | 5h 45 min                                       |
| 7762 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Prematurity</u>   |  |  |  |   |   |  |  |   |   |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (c)   |  |  |  |   |   |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |  |  |   |   |
| 7775  |  |  |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?  |   |   |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |   |
|   |  |  |  |   |   |  |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC) |  | 21f. LOCATION   |   | Street or R.F.D. No.   |  | City or Town County State                   |   |
|   |  |  |  |   |   |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 22</u> , 1968, to <u>Dec 23</u> , 1968, that (I) (we) last<br>saw the deceased alive on <u>Dec 23</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |   |   |
| 22b. SIGNATURE  |  |  |  |   | DEGREE  |  | ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/><br>PHYS. DIRECTOR PHYS. |   | 22c. DATE SIGNED                                |
| William Bryan, M.D.   |  |  |  |   |   |  |  |   | Dec 23, 1968                                    |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |  |  |   | 22e. ADDRESS  |  |  |   |   |
| W. Bryan, M.D. 7600 Carroll Ave,  |  |  |  |   | Takoma Park, Maryland 20012   |  |  |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)   |  | (County) (State)                            |   |
|   |  | 12/24/68   |  | Wash. San. & Hospital   |   | Takoma Park  |  | Montgomery, Md.                             |   |
| 24. FUNERAL DIRECTOR  |  |  |  |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                      |
| J. Ruffcorn 7600 Carroll Ave, T. P. Maryland  |  |  |  |   |   |  | DEC 27 1968  |   | J. Charles Judge                                |



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VR A15 (4)  
45M 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |                   |  |  |   |  |  |                   |  |
|--|--|---|-------------------|--|--|---|--|--|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                   |  |  |   |  |  |                   |  |
| CERTIFICATE OF DEATH   |  |   |                   |  |  |   |  |  |                   |  |
| 1. DECEASED NAME (Type or print)   |  |   | First Middle Last |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |                   |  |
| MARGARET (N) STONEBRAKER   |  |   |                   |  |  | December Day 8 Year 1968  |  | 6 17 M   |                   |  |
| 3. SEX   |  | 4. RACE   |                   | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |  | F. UNDER 1 YEAR  |                   |  |
| Female   |  | White   |                   | SEPT 3, 1887   |  | 81 YRS  |  | MONTHS 2 DAYS 5  |                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                   |  |
| Wash DC  |  | U.S.A.  |                   |  |  | MONTGOMERY  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH  |  |   |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                   |  |
| BETHESDA   |  |   |                   | SUBURBAN HOSPITAL  |  | HOUSEWIFE   |  |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |   |                   | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   |  |
| MARYLAND   |  |   |                   | MONTGOMERY   |  | CHEVY CHASE   |  | 4403 BRADLEY LANE  |                   |  |
| 14. FATHER'S NAME  |  |   | First Middle Last |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | First Middle Last |  |
| UNKNOWN  |  |   | MacLennan         |  |  | Marsha  |  |  | UNKNOWN           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |   |                   | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT   |  | Address  |                   |  |
| NO   |  |   |                   | 578-01-8116  |  | VAY STONEBRAKER   |  | 1324 - Edgewood AVE, NORTON, MARYLAND  |                   |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))  |  |   |                   |  |  |   |  |  |                   |  |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the stomach 12 hrs. after abdominal exploration - Necrosis   |  |   |                   |  |  |   |  |  |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal obstruction  |  |   |                   |  |  |   |  |  |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cause undetermined - possibly infected burn   |  |   |                   |  |  |   |  |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe inanition, Pneumonia, Atherosclerotic heart disease, Cerebral embolism   |  |   |                   |  |  |   |  |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |                   |  |
| 12/7/68  |  | Intest. Obstruction   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |   |  |  |                   |  |
|  |  | HOUR A.M. Month Day Year P.M. 19  |                   |  |  |   |  |  |                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                   |  |
|  |  |   |                   |  |  |   |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1968, to 12/8, 1968, that (I) (we) last saw the deceased alive on 12/7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                   |  |  |   |  |  |                   |  |
| 22b. SIGNATURE   |  |   |                   | M.D. DEGREE  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22c. DATE SIGNED   |                   |  |
| Joseph A. Romeo  |  |   |                   |  |  |   |  | 12/8/68  |                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |                   | 22e. ADDRESS   |  |   |  |  |                   |  |
| Joseph A. Romeo M.D.   |  |   |                   | 8218 Wisconsin Ave., Bethesda, Md.   |  |   |  |  |                   |  |
| 23a. BURIAL OR CREMATION   |  | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                   |  |
| Burial   |  | 12-11-68  |                   | Rock Creek   |  | Washington D.C.   |  |  |                   |  |
| 24. FUNERAL DIRECTOR   |  |   |                   | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                   |  |
| ROBERT A. PUMPHREY   |  |   |                   | 7557 - WISCONSIN AVE BETHESDA MD   |  | DATE DEC 16 1968  |  | Charles Judge  |                   |  |



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VR A15 (4)  
30M REV. 1/68

| MARTYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                    |   |   |  |  |  |  |   |  |  |  |
|--|--|---|--------------------|---|---|--|--|--|--|---|--|--|--|
| 17954  |  | CERTIFICATE OF DEATH  |                    |   |   | 17965  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Irma</b>  |  |   | First <b>Lacey</b> |   |   | Middle <b>Street</b>   |  |  | 2a. DATE OF DEATH<br><b>Dec.</b> Month <b>5</b> Day <b>68</b> Year |   |  | 2b. HOUR<br><b>1</b> <b>A</b> M                |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |                    | 5. DATE OF BIRTH<br><b>6-20-10</b>  |   |  | 6. AGE (In years<br>lost <b>58</b> day)<br><b>58</b> YRS.    |  |  | H UNDER 1 YEAR<br>MONTHS <b>5</b> DAYS <b>10</b>                  |  | H UNDER 24 HRS.<br>HOURS <b>1</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Del.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><b>Montgomery</b>                      |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Montgomery General Hospital</b> |                    |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br><b>Homemaker</b> |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |                    | 13c. CITY OR TOWN<br><b>Glenwood</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |   |  |  |  |
| 14. FATHER'S NAME<br><b>Roy D. Simplor</b>   |  |   |                    | 15. MOTHER'S MAIDEN NAME<br><b>Carrie Warrenton</b>   |   |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO<br>(If yes give war or dates of service)<br><b>579 42 9297</b>                                |                    | 17. INFORMANT<br><b>Hospital Records</b>  |   |  |  | Address<br><b>Olney, Md.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cachexia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma, right breast with axillary &amp; mediastinal spread</b><br>(c) <b>19 mos.</b>  |  |   |                    |   |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |                    |   |   |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>7/24/67</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of rt. breast</b>                                       |                    |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>Yes</b> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, nat'l medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b>19</b>  |                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                       |                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/11/1964</b> , to <b>12/5/1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>12/5/1964</b> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>(did not)</del> view the body after death |  |   |                    |   |   |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles S. Whitaker, M.D.</b>   |  |   |                    | 22c. ADDRESS<br><b>Ten Oaks Road<br/>Clarksville, Md. 21029</b>   |   | 22d. DATE SIGNED<br><b>12/6/68</b>   |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Dr. Charles Whitaker</b>   |  |   |                    |   |   |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>12-7-68</b>   |                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bridgeville Memorial Bridgeville</b>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Del.</b> |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>HIGHBOTHAM SLACK<br/>FUNERAL HOME</b>   |  | ADDRESS<br><b>Ellicott City, Md</b>   |                    | 25a. REC'D BY REGISTRAR<br><b>DEC 10 1968</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>           |  |  |   |  |  |  |





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VS 457 (4)  
4-1-69

17965

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17966

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(Type or print) <i>HAZEL</i>   |  | First Middle Last<br><i>L. Sward</i>   |  | 2a DATE OF DEATH<br>Month <i>12</i> Day <i>29</i> Year <i>68</i>  |  | 2b HOUR<br>M  |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>   |  | 5 DATE OF BIRTH<br><i>1-16-1891</i>   |  | 6 AGE (In years last birthday)<br><i>77</i> YRS   |  |
| 7a BIRTHPLACE (State or foreign country)<br><i>Iowa</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br><i>Montgomery</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Suburban</i> |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>  |  | 13b COUNTY <i>Mont</i>   |  | 13c CITY OR TOWN <i>Cherry Chase</i>  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><i>William F. Lembourg</i>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Anna Chadenia</i>                             |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown (If yes give war or dates of service)  |  | 16b SOCIAL SECURITY NO<br><i>None</i>   |  |
| 17 INFORMANT<br><i>George G. Sward</i>  |  | Address<br><i>2825 Greenvale St. Md.</i>   |  | 18 CAUSE OF DEATH (Enter on any one cause per line for (a) (b) and (c))<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Atherosclerotic Heart Disease</i><br><i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>unk.</i>                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4301</i>  |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                               |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  | 21f LOCATION Street or R.F.D. No City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/27</i> , 19 <i>68</i> , to <i>12/29</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>12/28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><i>Allen M. Mondz</i>  |  |  |  | MD DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  | 22c DATE SIGNED<br><i>12/29/68</i>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>ALLEN M. MONDZAL</i>   |  |  |  | 22e. ADDRESS<br><i>5904 CHATSWORTH AVE</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b DATE<br><i>1-2-69</i>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill</i>  |  | 23d LOCAT ON (City or Town) (County) (State)<br><i>Suitland Prince G. Md.</i>               |  |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey<br>7557-Wisconsin Ave., Bethesda, Md.   |  |  |  | 25a REC'D BY REGISTRAR<br>DATE <i>JAN 6 1969</i>  |  | 25b REGISTRAR'S SIGNATURE<br><i>Henry Judge</i>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |   |   |   |                         |  |
|---|--|--|---|--|---|---|---|---|-------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |   |   |   |   |                         |  |
| 179676  |  |  |   |  |   |   |   |   |                         |  |
| 17967   |  |  |   |  |   |   |   |   |                         |  |
| CERTIFICATE OF DEATH  |  |  |   |  |   |   |   |   |                         |  |
| 1 DECEASED-NAME<br>(Type or print)  |  |  | First   |  | Middle  |   | Last  |   | 2a DATE OF DEATH        |  |
| Eleanor W. Swartwood  |  |  |   |  |   |   |   |   | Month Day Year          |  |
| 3 SEX   |  |  | 4 RACE  |  | 5 DATE OF BIRTH   |   | 6 AGE (In years last birthday)  |   | 2b HOUR                 |  |
| female  |  |  | white   |  | 10-16-84  |   | 84 YRS.   |   | 39                      |  |
| 7a BIRTHPLACE (State or foreign country)  |  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 COUNTY OF DEATH   |   | Md                      |  |
| Pennsylvania  |  |  | U. S. A.  |  |   |   | Montgomery  |   |                         |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |   | 12b KIND OF BUSINESS OR INDUSTRY  |   |                         |  |
| Bethesda  |  |  | Suburban Home   |  | private   |   |   |   |                         |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE   |  |  | 13b COUNTY  |  | 13c CITY OR TOWN  |   | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET AND NUMBER   |  |
| Md.   |  |  | Mont.   |  | Cherry Chase  |   |   |   | 4702 - Cherry Chase St. |  |
| 14 FATHER'S NAME  |  |  | First   |  | Middle  |   | Last  |   | 15 MOTHER'S MAIDEN NAME |  |
| Eileen Frances  |  |  | Verner  |  | Aledia  |   | Vance Kirk  |   |                         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT  |   | Address   |   |                         |  |
| no  |  |  | no  |  | Bertrice Collins  |   | Same as above   |   |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |   |   |   |   |                         |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anteroseptal myocardial infarction</u> 5 weeks   |  |  |   |  |   |   |   |   |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis obliterans</u>  |  |  |   |  |   |   |   |   |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>  |  |  |   |  |   |   |   |   |                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>fat</u>  |  |  |   |  |   |   |   |   |                         |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> |                         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b TIME OF INJURY   |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |   |                         |  |
|   |  | HOUR A.M. Month Day Year   |   |  |   |   |   |   |                         |  |
|   |  | P.M. 19  |   |  |   |   |   |   |                         |  |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION  |   | Street or R.F.D. No   |   | City or Town  |                         |  |
|   |  |  |   |  |   |   |   | County  |                         |  |
|   |  |  |   |  |   |   |   | State   |                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>68</u> to <u>12/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |   |   |                         |  |
| 22b SIGNATURE   |  | 22c DATE SIGNED  |   |  |   |   |   |   |                         |  |
| Robert R. Montgomery, M.D.  |  | 12/15/68   |   |  |   |   |   |   |                         |  |
| 22d PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |   |  |   |   |   |   |                         |  |
| ROBERT R. MONTGOMERY, M.D.  |  | 5411 CEDAR LANE BETHESDA, MD.  |   |  |   |   |   |   |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)  |   | (County) (State)  |                         |  |
| Burial  |  | 12-16-68   |   | Mt. View Cemetery  |   | Wellsburg, New York   |   |   |                         |  |
| 24 FUNERAL DIRECTOR   |  |  |   |  |   | 25a REC'D BY REGISTRAR  |   | 25b REGISTRAR'S SIGNATURE   |                         |  |
| ROBERT A. PUMPHREY, Bethesda, Maryland  |  |  |   |  |   | DATE DEC 18 1968  |   | Charles Judge   |                         |  |



1  
170-77

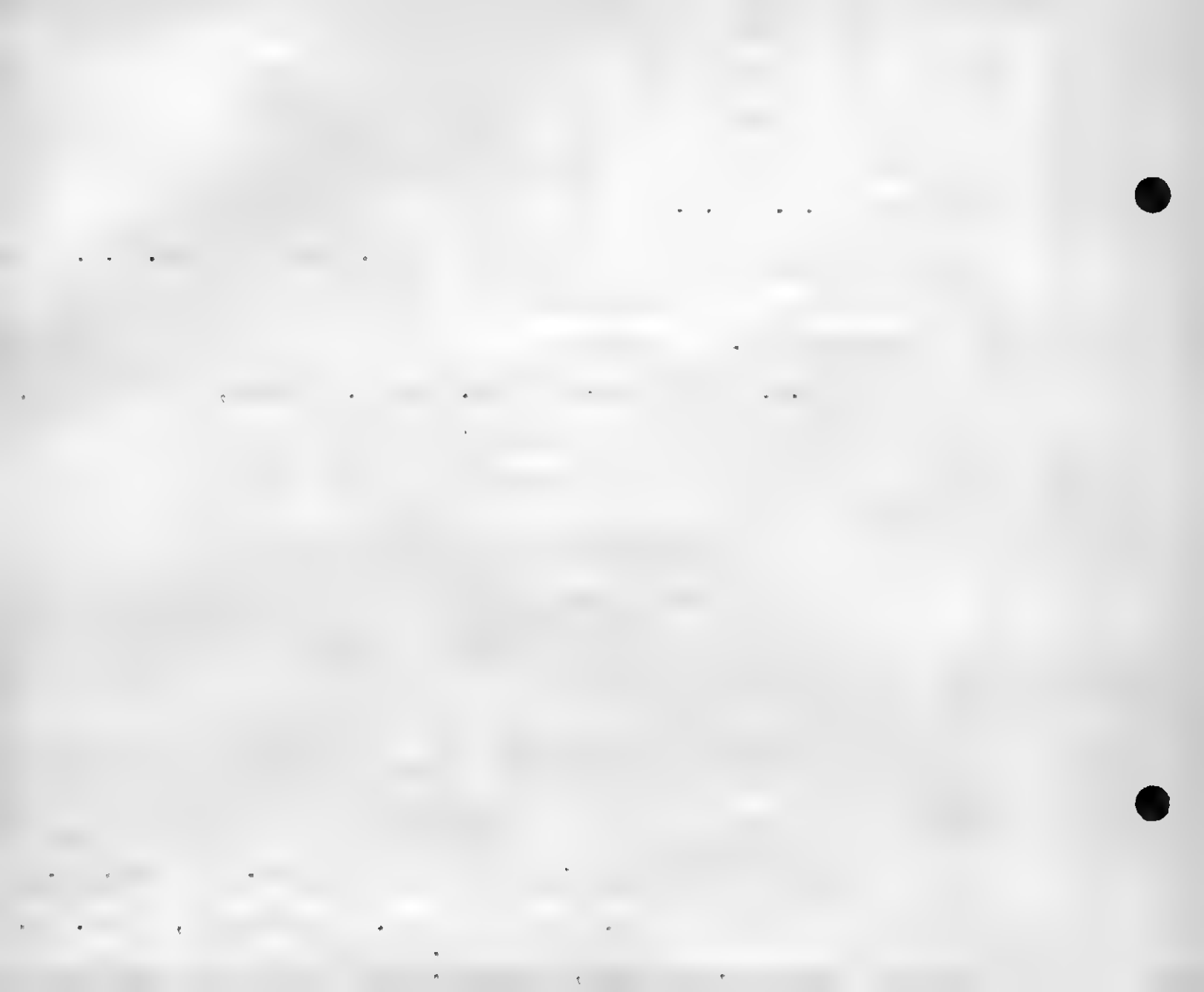
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17968

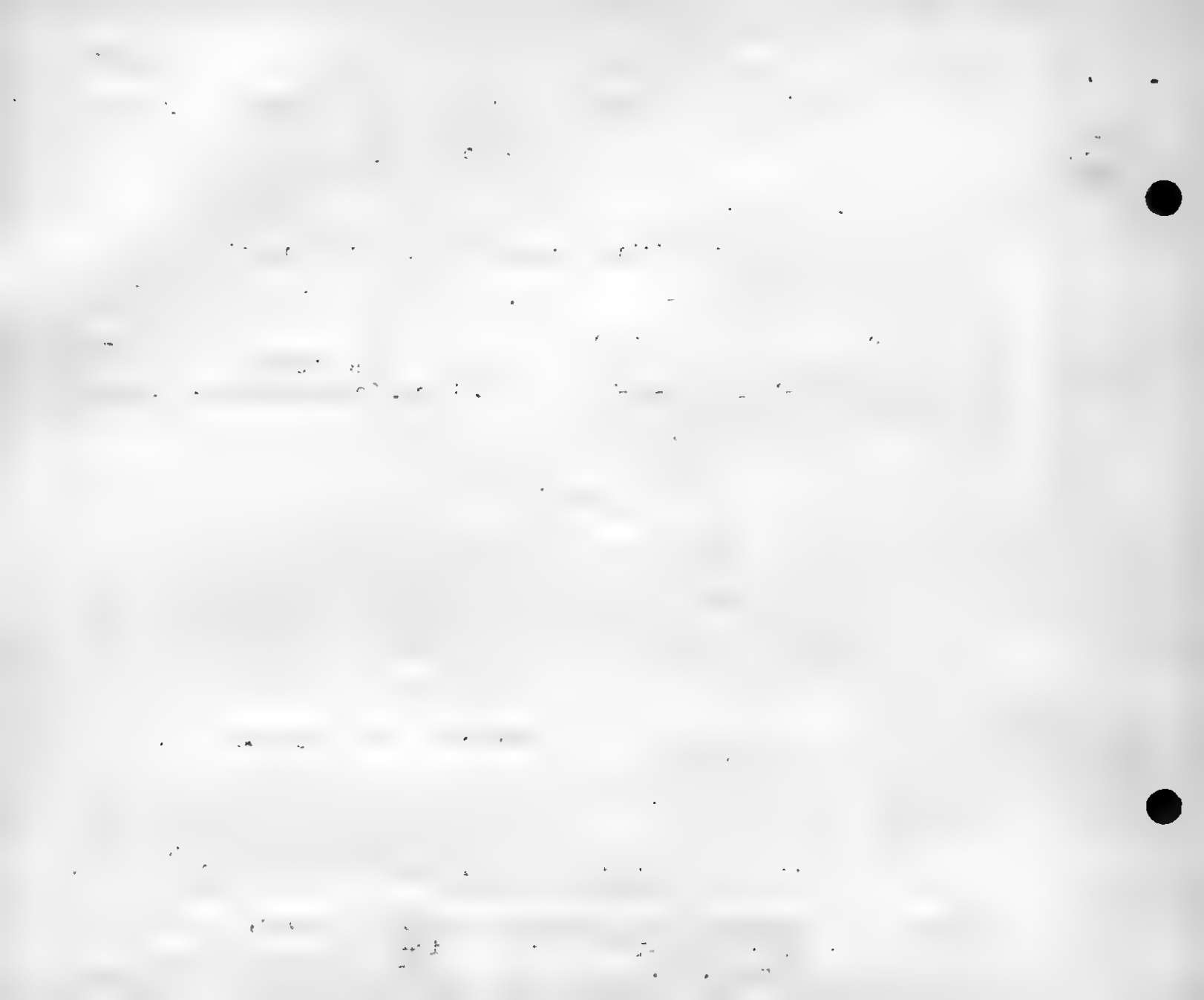
|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Robert J. Swingle</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>Dec</b> Day <b>3</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>5:17</b> M  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>white</b>   |   | 5 DATE OF BIRTH<br><b>10-30-86</b>   |  | 6 AGE (In years last birthday)<br><b>82</b> YRS                                      |  |
| 7a BIRTHPLACE (State or foreign country)<br><b>Washington D.C.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Suburban</b> |   | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)<br><b>Ret. Field Inspect.</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt</b>                                 |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE<br><b>Md.</b>   |  | 13b COUNTY<br><b>Montgomery</b>  |   | 13c CITY OR TOWN<br><b>Bethesda</b>  |  | 13d INS DE CITY L.M.T.S?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 13e STREET AND NUMBER<br><b>5601 Grosvenor Ln.</b>   |  | 14. FATHER'S NAME<br>First <b>Robert</b> Middle <b>D.</b> Last <b>Swingle</b>                  |   | 15 MOTHER'S MAIDEN NAME<br>First <b>Emma</b> Middle <b>Catherine</b> Last <b>Johnston</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |  | 16b SOCIAL SECURITY NO<br><b>W.W. L 578-44-1825</b>  |   | 7 INFORMANT<br><b>Mrs. Asha W. Swingle,</b>  |  | Address <b>as above.</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>4119</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Atherosclerosis</b> |  |  |   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |   |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                               |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |  |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |   | 21f LOCATION Street or R.F.D. No City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 8, 1961</b> , to <b>Dec. 3, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death                                     |  |  |   |  |  |  |  |
| 22b SIGNATURE<br><b>Robert G. Angle M.D.</b>   |  | DEGREE<br><b>ROBERT G. ANGLE, MD.</b>  |   | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                               |  | 22c DATE SIGNED<br><b>DEC. 3, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e ADDRESS<br><b>5009 DelRay Ave. Bethesda, Md.</b>   |   |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b DATE<br><b>12/6/68</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Geo. Washington Cem.</b>   |  | 23d LOCATION (City or Town) (County) (State)<br><b>Hyattsville, Montg. Md.</b>       |  |
| 24 FUNERAL DIRECTOR<br><b>Robert A. Pomphrey</b>   |  | 7557 Wisconsin Ave.<br><b>Bethesda, Maryland</b>   |   | 25a REC'D BY REG STRAR<br><b>DEC 9 1968</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                    |  |



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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
|---|--|--|---|--|--|--|--|--|--|--|--|--|--|------------------------------------|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First<br><b>William</b>   |  |  | Middle<br><b>Anthony</b>   |  |  | Last<br><b>Taddeo</b>  |  |  | 2a. DATE OF DEATH<br>Month<br><b>December</b> Day<br><b>19</b> Year<br><b>1968</b> |  |                                    | 2b. HOUR PM<br><b>10:00</b> |  |
| 3 SEX<br><b>Male</b>  |  |  | 4 RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>June 12, 1939</b>   |  |  | 6. AGE (In years last birthday)<br><b>29</b> YRS.  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS<br>MIN |                             |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  | Md   |  |                                    |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>The Clinical Center, NIH</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Warehouse Supervisor</b>                                      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                                    |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>New Jersey</b>  |  |  | 13b. COUNTY<br><b>--</b>  |  |  | 13c. CITY OR TOWN<br><b>Union</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>916 Lakeside Place</b>                                |  |                                    |                             |  |
| 14. FATHER'S NAME<br>First<br><b>Ned</b>  |  |  | Middle<br><b>Taddeo</b>   |  |  | Last<br><b>Mary</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Mary</b>   |  |  | Middle<br><b>LaFerrara</b>   |  |                                    |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO<br><b>1959-1961 143-30-0983</b>   |  |  | 17. INFORMANT<br><b>The Medical Record</b>   |  |  | Address<br><b>The Clinical Center, Bethesda, Maryland</b>                                    |  |  |  |  |                                    |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |                                    |                             |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis, shock</b>  |  |  |   |  |  |  |  |  |  |  |  | <b>24 Hours</b>  |  |                                    |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myelogenous Leukemia</b>   |  |  |   |  |  |  |  |  |  |  |  | <b>1 1/2 Years</b>   |  |                                    |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
|   |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>              |  |  |  |  |                                    |                             |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |  |  |  |  |  |  |                                    |                             |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No  |  |  | City or Town   |  |  | County   |  | State                              |                             |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 3, 1968</b> to <b>December 19, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 19, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| 22b. SIGNATURE<br><b>Brian W. Goodell</b>   |  |  | DEGREE  |  |  | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                               |  |  | 22c. DATE SIGNED<br><b>20 December 1968</b>  |  |  |  |  |                                    |                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Brian W. Goodell, M. D.</b>  |  |  | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>                        |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12/24/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>   |  |  | 23d. LOCATION (City or Town)<br><b>Hanover, New Jersey</b>                                   |  |  | (County)   |  | (State)                            |                             |  |
| 24. FUNERAL HOME<br><b>Tyson Wheeler Funeral Home-1531 Rockville Pike<br/>Rockville, Md.</b>  |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| 25. REC'D BY REGISTRAR<br><b>DEC 26 1968</b>  |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |   |  |  |  |  |  |  |  |  |  |  |                                    |                             |  |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17050

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17870

|   |                     |   |   |  |  |  |  |  |
|---|---------------------|---|---|--|--|--|--|--|
| 1 DECEASED-NAME<br>(Type or Print) <i>Andrew Clifford Tait</i>  |                     |   | 2a DATE KNOWN OF DEATH<br>ESTIMATED <i>Dec. 9 1968</i>                          |  |  | 2b HOUR <i>8:30 M</i>  |  |  |
| 3 SEX <i>male</i>   | 4 RACE <i>white</i> | 5 DATE OF BIRTH <i>4/4/1915</i>   | 6 AGE (in years last birthday) <i>53</i> YRS                                    | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>   | IF UNDER 24 HRS<br>HOURS <i></i> MIN <i></i> | 2c DATE PRONOUNCED DEAD<br>Month <i>Dec</i> Day <i>9</i> Year <i>1968</i>          |  |  |
| 7a BIRTHPLACE (State or foreign country) <i>Conn.</i>   |                     | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Montgomery</i> Md  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i>   |                     | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i> |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Boat.</i>   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a USUAL RESIDENCE (Where deceased lived if institution on admission) STATE <i>Va.</i>   |                     | 13b COUNTY <i>Warrenton</i>   |   | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET AND NUMBER <i>3316 North Custis Dr.</i>   |
| 14 FATHER'S NAME<br>First <i>Andrew</i> Middle <i>Tait</i> Last <i></i>   |                     |   | 15 MOTHER'S MAIDEN NAME<br>First <i>Laura</i> Middle <i>Wilson</i> Last <i></i> |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>   |                     |   | 16b SOCIAL SECURITY NO <i>070-05-0612</i>                                       |  |  | 17. INFORMANT <i>Reid C. Tait</i> ADDRESS <i>206 - Hixley Pkwy, Rockville, Md.</i> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Coronary Artery Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Arterio-Sclerosis Generalized</i>  |                     |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden.</i><br><br><i>years</i><br><br><i>years</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>420</i>   |                     |   |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |                     |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?                                |  |  | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                     | 21b TIME OF INJURY Month, Day, Year<br>HOUR A.M. <i>19</i> P.M. <i></i>                     |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                 |   | 21f LOCATION Street or RFD No  |  | City or Town   |  | County State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                     |   |   |  |  |  |  |  |
| ACTUAL SIGNATURE <i>John G. Ball</i>  |                     |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                 |  |  | 22b DATE SIGNED <i>Dec. 9, 1968</i>  |  |  |
| EXAMINER'S NAME (Type) <i>John G. Ball</i>  |                     |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                     |  |  | ADDRESS (Street, city, town, or county)  |  |  |
| 23a BURIAL CREMATION, REMOVAL (Specify)   |                     | 23b DATE <i>12/13/68</i>  |   | 23c NAME OF CEMETERY OR CREMATORY <i>Yonkers Cr. &amp; Bury. Co.</i>   |  | 23d LOCATION (City or Town) (County) (State) <i>Baltimore Md. Md.</i>              |  |  |
| 24 FUNERAL DIRECTOR <i>Tyson Wheeler</i>  |                     |   |   | ADDRESS <i>Funer 1 Tone 171 Rockville, Md.</i>   |  | 25a REC'D BY REG STRAR<br>DATE <i>DEC 16 1968</i>                                  |  | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  |   |  | 17971  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|
| 12/31/68 11w 17990  |  |  |  |  |  |  |  |  |  |   |  | CERTIFICATE OF DEATH                         |
| 1. DECEASED-NAME (Type or print) <b>George</b> First <b>Tait</b> Middle <b>Tait</b> Last  |  |  |  |  |  | 2a. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1968</b>                                 |  |  | 2b. HOUR <b>8 A/M</b>                            |   |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>8-13-1376</b>  |  | 6. AGE (In years lost birthday) <b>92</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                          |  | IF UNDER 24 HRS. HOURS <b></b> M.N. <b></b> |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Wash, D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Montgomery</b> Md.   |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>259 Congressional Lane</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>...P.O.</b> |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b> COUNTY <b>Montgomery</b>  |  |  |  | 13c. CITY OR TOWN <b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET AND NUMBER <b>259 Congressional Lane</b>                 |  |   |  |  |
| 14. FATHER'S NAME First <b>Joseph</b> Middle <b>Tait</b> Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Henrietta</b> Middle <b>Mullen</b> Last  |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO. <b>579 60 1140</b>  |  | 17. INFORMANT Address <b>Mary A. Tait Same as 13 above</b>   |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>(b) Stress ulceration of stomach.</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) Recurrent Cerebral Thrombosis</b>  |  |  |  |  |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>332x Renal Failure</b>  |  |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)                                |  | 21f. LOCATION Street or R.F.D. No City or Town County State  |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 16</b> , 1968, to <b>Dec 17</b> , 1968, that (I) (we) last saw the deceased alive on <b>Dec 16</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE <b>James R. Moore Jr</b> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  | 22c. DATE SIGNED <b>Dec 17, 1968</b>   |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>James R. Moore Jr</b>   |  |  |  |  |  | 22e. ADDRESS <b>570 N. Frederick Ave Gaithersburg</b>  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <b>12-14-1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Wash, D.C.</b>  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR <b>Robert A. Mattingly</b>   |  | ADDRESS <b>131-11 N. 1st St. Wash</b>  |  | 25a. REC'D BY REGISTRAR <b>DEC 20 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17951

CERTIFICATE OF DEATH

17972

|  |  |   |   |   |  |   |  |   |         |  |
|--|--|---|---|---|--|---|--|---|---------|--|
| 1 DECEASED NAME<br>(Type or print) <i>Leslie Britton Taylor</i>  |  |   | 2a. DATE OF DEATH<br>Month <i>Dec.</i> Day <i>17</i> Year <i>1968</i>   |   |  | 2b. HOUR<br><i>P.M.</i>   |  |   |         |  |
| 3. SEX<br><i>Male</i>  |  | 4 RACE<br><i>Caucasian</i>  |   | 5 DATE OF BIRTH<br><i>3-26-90</i>   |  | 6 AGE (In years<br>last birthday)<br><i>78</i> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS                        |         |  |
| 7a BIRTHPLACE (State or foreign<br>country) <i>New Jersey</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>Amer.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><i>Montgomery Co.</i> Md.                                      |  |   |         |  |
| 10 CITY OR TOWN OF DEATH<br><i>Takoma Park</i>   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>Washington San. &amp; Hosp. Grounds Care of Wash.</i> |   | 12a USUAL OCCUPATION and of work done<br>during most of working life, even if retired   |  | 12b KIND OF BUSINESS OR<br>INDUSTRY   |  |   |         |  |
| 13a USUAL RESIDENCE (Where deceased lived if institution. Residence before<br>admission) STATE <i>Maryland</i>   |  | 13b COUNTY<br><i>Montgomery</i>   |   | 13c CITY OR TOWN<br><i>Spencerville</i>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET AND NUMBER<br><i>1901 Spencerville Rd.</i> |         |  |
| 14 FATHER'S NAME First Middle Last<br><i>Benjamin B. Taylor</i>  |  |   | 15 MOTHER'S MAIDEN NAME First Middle Last<br><i>Elizabeth L. Wilson</i> |   |  |   |  |   |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>No</i>  |  |   | 16b SOCIAL SECURITY NO<br><i>141-16-0272</i>                            |   | 17. INFORMANT<br><i>Patient &amp; Wife</i> |   |  |   | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |         |  |
| PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Electrolyte Imbalance &amp; Anoxemia</i><br><i>600 x</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last <i>610 x</i><br>(b) <i>Acute Renal Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Self-induced Abstinence &amp; R. Medical History</i> |  |   |   |   |  |   |  |   |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Benign Paroxysmal Tachycardia, Partially Corrected Self-induced Cardiac Transmural Infarction</i>  |  |   |   |   |  |   |  |   |         |  |
| 19a DATE OF OPERATION<br><i>12-10-68</i>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Hematuria</i>   |   | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <i>Yes</i>   |  |   |         |  |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |         |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)<br>OFFICE, BUILDING, ETC.  |   | 21f LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> , 1968, to <i>12/17</i> , 1968, that (I) (we) last<br>saw the deceased alive on <i>12/17</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death  |  |   |   |   |  |   |  |   |         |  |
| 22b. SIGNATURE<br><i>Douglas R. Batts MD</i>   |  | DEGREE  |   | ATTENDING<br>PHYS <input checked="" type="checkbox"/> MED<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS <input type="checkbox"/>                       |  | 22c DATE SIGNED<br><i>12/18/68</i>  |  |   |         |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e ADDRESS<br><i>831 University Blvd E. Silver Spring Md</i>   |   |   |  |   |  |   |         |  |
| 23a BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b DATE<br><i>Dec. 20, 1968</i>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><i>George Washington</i>   |  | 23d LOCATION (City or Town) (County) (State)<br><i>Adelphi Md</i>                   |  |   |         |  |
| 24 FUNERAL DIRECTOR<br><i>John J. Walters</i>  |  | ADDRESS<br><i>251 Bernollet St NW</i>   |   | 25a REC'D BY REGISTRAR<br>DATE <i>DEC 20 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Charles Judge</i>                             |  |   |         |  |

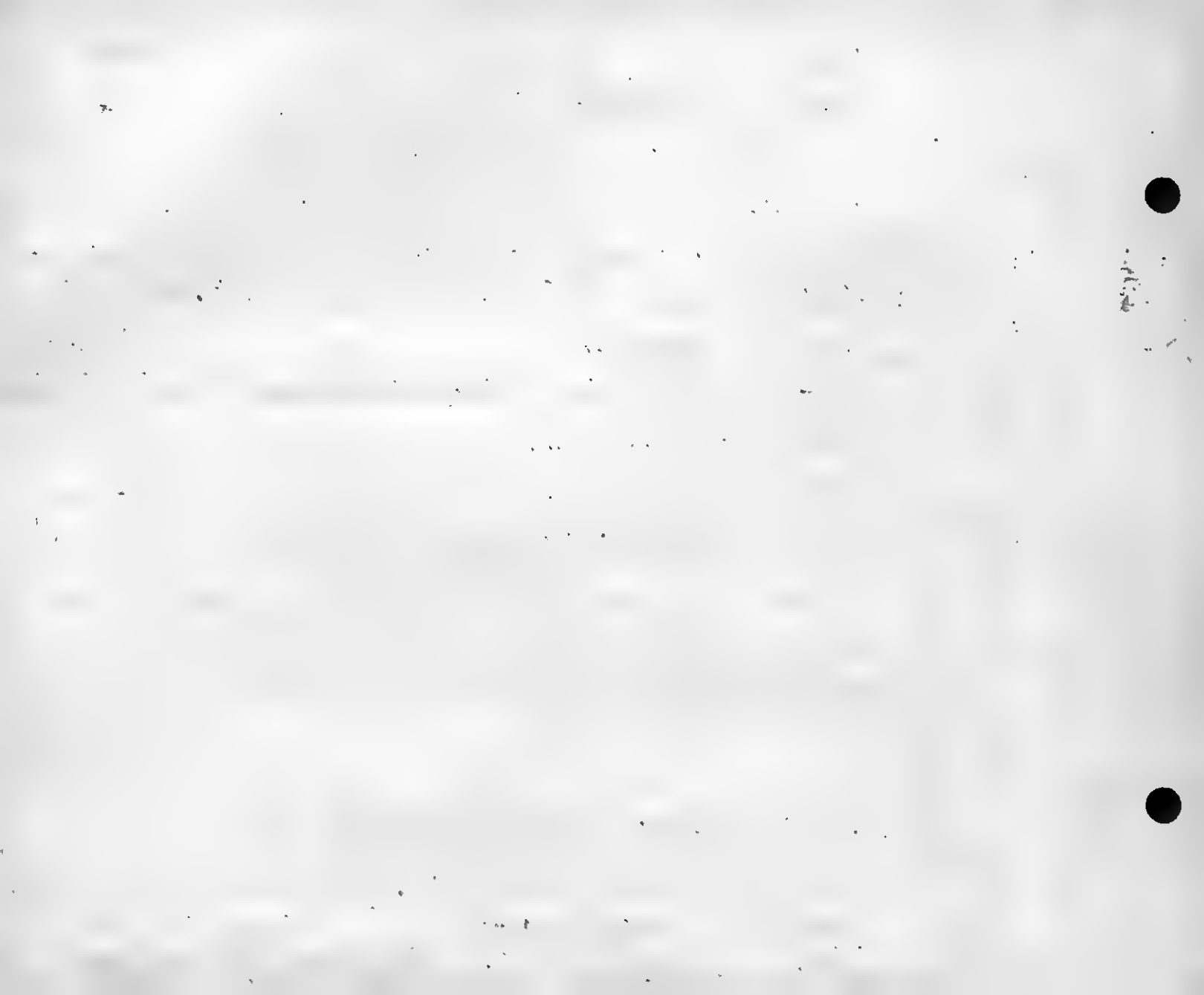


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Coroner Dr. Better Keap.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |                             |  |  |
|---|--|--|--|---|--|---|--|--|-----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |                             |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                             |  |  |
| 1 DECEASED NAME (Type or print) First MARY Middle Wilson Last TAYLOR  |  |  |  |   |  | 2a DATE OF DEATH Month 12 Day 12 Year 68  |  |  | 2b HOUR 10 <sup>50</sup> AM |  |  |
| 3. SEX Female   |  | 4. RACE CAUCASIAN  |  | 5. DATE OF BIRTH 9-6-01   |  | 6. AGE (In years last birthday) 67 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS              |                             | IF UNDER 24 HRS HOURS MIN  |  |
| 7a BIRTHPLACE (State or foreign country) Maryland   |  | 7b CITIZEN OF WHAT COUNTRY? U.S. America   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH MONTGOMERY Md.   |  |  |                             |  |  |
| 10 CITY OR TOWN OF DEATH TAKOMA PARK  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN+HOSP. |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) clerk - Hecht Co.   |  | 12b KIND OF BUSINESS OR INDUSTRY Dept. Store  |  |  |                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  | 13b COUNTY Montgomery  |  | 13c CITY OR TOWN S. Sp.   |  | 13d INSIDE CITY LIM 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET AND NUMBER 233 Whitmoor Terr. |                             |  |  |
| 14. FATHER'S NAME First Lee Middle -- Last Wilson   |  |  |  | 15 MOTHER'S MAIDEN NAME First Ida Middle -- Last Laird  |  |   |  |  |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO   |  | 16b. SOCIAL SECURITY NO 213-14-6075  |  | 17 INFORMANT John C. Phacey   |  | Address Sil. Spr. Md. 233 Whitmoor Terrace  |  |  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC TAMPONADE<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) RUPTURE OF POSTERIOR APICAL MYOCARDIUM<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) POSTERIOR APICAL MYOCARDIAL INFARCTION |  |  |  |   |  |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>SUDDEEN<br>16 HOURS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |                             |  |  |
| 19a. DATE OF OPERATION 4-21-68  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |  |  |                             |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |   |  |  |                             |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                     |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County                                   |                             | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-11, 1968, to 12-12, 1968, that (I) (we) last saw the deceased alive on 12-11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |  |  |   |  |   |  |  |                             |  |  |
| 22b. SIGNATURE Seruech T. Kimble, M.D.  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                  |  | 22c. DATE SIGNED 12-12-68.  |  |  |                             |  |  |
| 22d. PHYSICIAN'S NAME (Type) Seruech T. Kimble, MD  |  |  |  | 22e. ADDRESS 9801 Georgia Ave. S.S. Md.   |  |   |  |  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 23b. DATE 12-15-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY Monokon Presbyterian Church Cem.   |  | 23d. LOCATION (City or Town) Princes Anne,  |  | (County) Maryland                        |                             | (State)  |  |
| 24 FUNERAL DIRECTOR J.W. Lee Warner E. Pumphrey, Inc. 8434 Georgia Avenue   |  |  |  | ADDRESS Sil. Spr. Md.   |  | 25a. REC'D BY REGISTRAR DEC 19 1968   |  | 25b. REGISTRAR'S SIGNATURE Charles Judge |                             |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Deceased by Dr. Lee - Medical Examiner

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 17903  |  |  |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |
| 17974  |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(Type or print) <i>Mrs. Minerva H. Taylor</i>  |  |  | 2a. DATE OF DEATH<br>Month <i>December</i> Day <i>10</i> Year <i>1968</i>            |   |  | 2b. HOUR<br><i>7<sup>30</sup> p.m.</i>   |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>November 24, 1881</i>  |  | 6. AGE (In years last birthday)<br><i>87</i> YRS   |  | 7. UNDER 1 YEAR<br>MONTHS <i>1</i> DAYS <i>10</i>         |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>New Jersey</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Montgomery</i>  |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Wheaton</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Randolph Hills Nursing Home</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>own home</i>   |  |   |  |
| 13a. U.S. RESIDENCE (Where deceased lived, if institution residence before admission) STATE<br><i>Silver Sp. Md.</i>   |  | 13b. COUNTY<br><i>Montgomery</i>   |  | 13c. CITY OR TOWN<br><i>Silver Spring</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>2108 Belvedere Boulevard</i> |  |
| 14. FATHER'S NAME<br>First <i>Christian A.</i> Middle <i>Neil</i> Last <i>Sweet</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Cornelia</i> Middle <i>--</i> Last <i>Sweet</i> |   |  | Address <i>Rockville, Md.</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>192-26-1548</i>   |  | 17. INFORMANT<br><i>H. Laessle Taylor</i>   |  | Address <i>4105 Southend Road</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis of heart disease 30 yrs</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 units</i>   |  |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>none</i>  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)                                      |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>67</i> , to <i>Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>23 Oct</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>James M.D.</i>  |  | 22c. DATE SIGNED<br><i>16 Dec 68</i>   |  | 22d. PHYSICIAN'S NAME (Type)<br><i>BUT T. Nouns M.D.</i>  |  |  |  |   |  |
| 22e. ADDRESS<br><i>5201 Randolph Rd, Rockville, Md.</i>  |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>12-21-1968</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenwood Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Trenton, New Jersey</i>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>J.W. Lee</i>  |  | ADDRESS<br><i>Sil. Spr. Md.</i>  |  | 25a. REC'D BY REG. STRAR<br><i>DEC 23 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James Judge</i>   |  |   |  |
| Warner E. Humphrey, Inc. 8434 Georgia Avenue   |  |  |  |   |  |  |  |   |  |



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 18-22a Film 409 Maryland State Department of Health  
2-7-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17975

|  |                 |   |   |  |                              |
|--|-----------------|---|---|--|------------------------------|
| 1 DECEASED NAME<br>(Type or Print) First Middle Last<br><b>WILLIAM FLOYD TAYLOR</b>  |                 |   | 2a DATE KNOWN OF DEATH<br>Month Day Year<br><b>12 28 1968</b> |  | 2b HOUR<br>9:52 PM           |
| 3 SEX<br>Male  | 4 RACE<br>White | 5 DATE OF BIRTH<br>11-19-39   | 6 AGE (in years last birthday)<br>29 YRS                      | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)<br>North Carolina   |                 | 7b CITIZEN OF WHAT COUNTRY?<br>United States  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              |
| 9 COUNTY OF DEATH<br>Montgomery  |                 | 10 CITY OR TOWN OF DEATH<br>Olney   |   | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Montgomery General Hospital   |                              |
| 12a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE<br>North Carolina   |                 | 12b COUNTY<br>Onslow  |   | 12c CITY OR TOWN<br>Jacksonville   |                              |
| 13a STREET AND NUMBER<br>404 Clyde Drive   |                 | 13b INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 13c USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Manager  |                              |
| 14 FATHER'S NAME First Middle Last<br>Preston Taylor   |                 | 15 MOTHER'S MAIDEN NAME First Middle Last<br>Eva Turner   |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>yes   |                              |
| 16b SOCIAL SECURITY NO.  |                 | 17. INFORMANT ADDRESS<br>Admission Recd., Montgomery Gen. Hospital, Olney, Md.  |   |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull with intracranial hemorrhage incurred in auto accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Edema</u><br>(c) <u>Traumatic Necrosis, Cerebral</u>  |                 |   |   |  |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Thrombocytopenic Purpura</u>  |                 |   |   |  |                              |
| 19a DATE OF OPERATION<br>1/2/69  |                 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Hypertension   |   | 20 AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                 | 21b TIME OF INJURY Month, Day, Year<br>Dec 25 1968  |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)<br>Thrown from Auto when it struck a tree                                    |                              |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                 | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Street   |   | 21f LOCATION Street or R.F.D. No. City or Town County State<br>Rtes. 29 & 108 Howard Md.   |                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                 |   |   |  |                              |
| ACTUAL SIGNATURE<br>Belden R. Reap   |                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br>12/29/1968   |                              |
| EXAMINER'S NAME (Type) Belden R. Reap  |                 | ADDRESS (Street, City, Town, or County)<br>Baltimore, Md.   |   |  |                              |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br>Burial, Removal  |                 | 23b DATE<br>12/30/68  |   | 23c NAME OF CEMETERY OR CREMATORY<br>Onslow Memorial Park  |                              |
| 23d LOCATION (City or Town) (County) (State)<br>Jacksonville North Carolina  |                 | 24. FUNERAL DIRECTOR ADDRESS<br>The Demaine Funeral Homes, Inc. Alexandria Va.  |   | 25a REC'D BY REGISTRAR<br>JAN 2 1969   |                              |
|  |                 | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |  |                              |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |        |   |   |   |                                 |   |  |                         |  |        |  |         |
|---|--------|---|---|---|---------------------------------|---|--|-------------------------|--|--------|--|---------|
| 1 DECEASED-NAME<br>(Type or Print)  |        |   | First   | Middle  | Last                            | 2a DATE KNOWN OF DEATH ESTI- MATED  |  |                         | <input checked="" type="checkbox"/> Month    | Day    | Year   | 2b HOUR |
| Clara B. Terhune  |        |   |   |   |                                 | Dec 24 19 68  |  |                         |  |        |  | PM      |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH   | 6 AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                 | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c DATE PRONOUNCED DEAD |  |        | 2d HOUR                                      |         |
| Female  | White  | 4-10-82   | 86 YRS  |   |                                 |   |  | Month Day Year          |  |        | PM   |         |
| 7a. BIRTHPLACE (State or foreign country)   |        | 7b CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9 COUNTY OF DEATH   |  |                         | 10   |        |  |         |
| New Jersey  |        | U.S.A.  |   |   |                                 | Montgomery Md   |  |                         |  |        |  |         |
| 11a CITY OR TOWN OF DEATH   |        | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |                                 | 12b KIND OF BUSINESS OR INDUSTRY  |  |                         |  |        |  |         |
| Bethesda  |        | Suburban  |   | Housewife   |                                 |   |  |                         |  |        |  |         |
| 13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE  |        | 13b. COUNTY   |   | 13c CITY OR TOWN  |                                 | 3d INSIDE CITY, J.M.T.S?  |  | 13e STREET AND NUMBER   |  |        |  |         |
| Maryland  |        | Montgomery  |   | Chevy Chase   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 4125 Ieland Street      |  |        |  |         |
| 14 FATHER'S NAME  |        |   | First   | Middle  | Last                            | 15 MOTHER'S MAIDEN NAME   |  |                         | First  | Middle | Last   |         |
| Edward C Bennett  |        |   |   |   |                                 | Annie E. Whitlock   |  |                         |  |        |  |         |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)  |        |   | 16b SOCIAL SECURITY NO  |   | 17 INFORMANT                    |   |  | ADDRESS                 |  |        |  |         |
|   |        |   | 020-18-9203   |   | Mrs. T. Harold Scott - Daughter |   |  | same as above           |  |        |  |         |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))  |        |   |   |   |                                 |   |  |                         |  |        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>  |        |   |   |   |                                 |   |  |                         |  |        | 7 hr.  |         |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease-</u>  |        |   |   |   |                                 |   |  |                         |  |        | Years  |         |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>  |        |   |   |   |                                 |   |  |                         |  |        | Years  |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |        |   |   |   |                                 |   |  |                         |  |        |  |         |
| 47 <u>Fracture of Left Hip.</u>   |        |   |   |   |                                 |   |  |                         |  |        |  |         |
| 19a DATE OF OPERATION   |        |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |   |                                 | 20 AUTOPSY?   |  |                         |  |        |  |         |
| Dec- 24, 1968   |        |   | Repair of fracture of left hip.   |   |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                         |  |        |  |         |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |        |   | 21b TIME OF INJURY Month, Day, Year   |   |                                 | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |  |                         |  |        |  |         |
|   |        |   | 7 P.M. Dec 22 1968  |   |                                 | Fall in nursing home  |  |                         |  |        |  |         |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |        |   | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |                                 | 21f LOCATION Street or R.F.D. No  |  |                         | City or Town                                 |        |  |         |
|   |        |   | Nursing Home  |   |                                 | Potomac Valley Nursing Home   |  |                         | Rockville Mont. Md.                          |        |  |         |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        |   |   |   |                                 |   |  |                         |  |        |  |         |
| ACTUAL SIGNATURE  |        |   | EXAMINER'S NAME (Type)  |   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                               |  |                         | 22b DATE SIGNED                              |        |  |         |
| John M. Ball  |        |   |   |   |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                           |  |                         | Dec 24, 1968                                 |        |  |         |
|   |        |   |   |   |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                   |  |                         |  |        |  |         |
|   |        |   |   |   |                                 | ADDRESS (Street, city, town, or county)                                       |  |                         |  |        |  |         |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |        |   | 23b DATE  |   |                                 | 23c NAME OF CEMETERY OR CREMATORY   |  |                         | 23d LOCATION (City or Town) (County) (State) |        |  |         |
| Removal   |        |   | 12/26/68  |   |                                 | Bound Brook Cemetery  |  |                         | Bound Brook, N. Jersey                       |        |  |         |
| 24 FUNERAL DIRECTOR   |        |   | ADDRESS   |   |                                 | 25a REC'D BY REGISTRAR  |  |                         | 25b REGISTRAR'S SIGNATURE                    |        |  |         |
| The S.H.Hines Company Washington, D.C.  |        |   |   |   |                                 | DEC 27 1968   |  |                         | J. Charles Judge                             |        |  |         |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

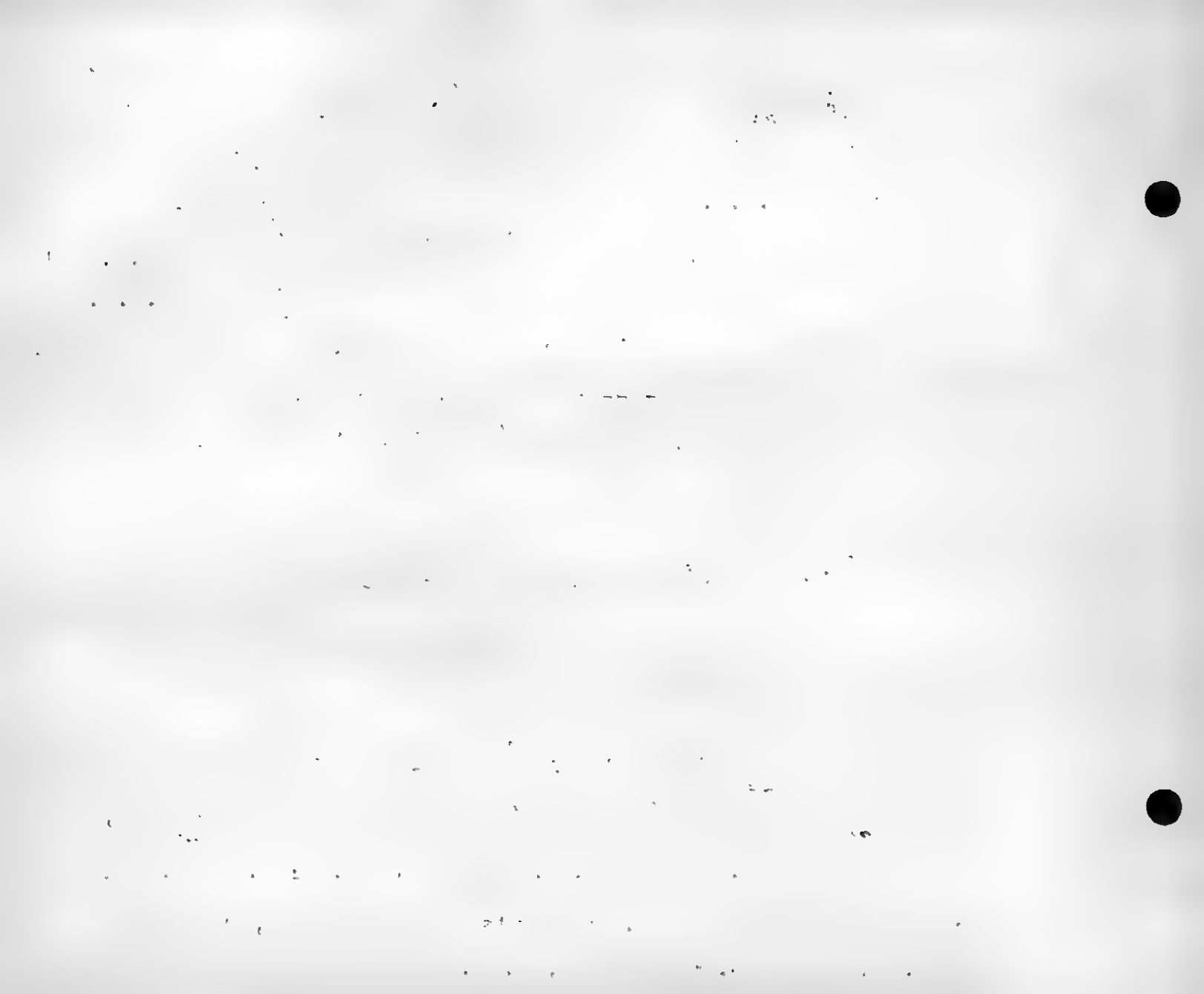
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17996

CERTIFICATE OF DEATH

17977

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEASED NAME<br>(Type or print) <b>MARY E. Thiesen</b>   |   | 2a. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>27</b> Year <b>1968</b>   |   | 2b. HOUR<br><b>1:25 PM</b>                          |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br><b>2/16/1895</b>  |   | 6. AGE (In years last birthday)<br><b>73</b> YRS.   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Montgomery</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not at home, give street address)<br><b>Colonial Villa Home Nursing</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Secretary</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>   |   | 13b. CITY OR TOWN<br><b>Washington</b>  | 13c. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13d. STREET AND NUMBER<br><b>1916 17th St. N.W.</b> |
| 14. FATHER'S NAME First Middle Last<br><b>Patrick Sexton</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Collins</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO<br><b>378-10-3576A</b>  |   |   |
| 17. INFORMANT<br><b>Nursing Home Records (same as above)</b>   |   | Address   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal rectal cancer</b><br>1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>2 years</b> |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Recurrent urinary tract infections.</b>  |   |   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 20, 1968</b> to <b>Dec 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |
| 22b. SIGNATURE<br><b>Donald W. Datlow, M.D.</b>  |   | ATTENDING PHYSICIAN<br>DEGREE <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          | 22c. DATE SIGNED<br><b>Dec 27, 1968</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Donald W. Datlow, M. D.</b>   |   | 22e. ADDRESS<br><b>823 Univ. Blvd. West. Silver Spg</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>12/28/68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Raymond's Cemetery Bronx, New York</b>   | 23d. LOCATION (City or Town) (County) (State)   |   |
| 24. FUNERAL DIRECTOR<br><b>The S. H. Hines Co. Washington, D. C.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 31 1968</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17978

|   |                        |  |  |   |                                  |  |  |   |
|---|------------------------|--|--|---|----------------------------------|--|--|---|
| 1 DECEASED NAME<br>(Type or Print) <i>Alice Elizabeth Thomas</i>  |                        |  | 2a DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month <i>12</i> Day <i>15</i> Year <i>1968</i> |   |                                  | 2b HOUR <i>2:38</i> PM   |  |   |
| 3 SEX<br><i>Female</i>  | 4 RACE<br><i>White</i> | 5 DATE OF BIRTH<br><i>3-22-1890</i>  | 6 AGE (In years last birthday)<br><i>78</i> YRS  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS<br>HOURS<br>MINS | 2c DATE PRONOUNCED DEAD<br>Month <i>12</i> Day <i>15</i> Year <i>1968</i>                      |  |   |
| 7a BIRTHPLACE (State or foreign country)<br><i>Wash., D.C.</i>  |                        | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |                                  | 9. COUNTY OF DEATH<br><i>Montgomery</i> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |                        | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Holy Cross Hosp.</i> |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Accountant</i>  |                                  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>Motor Co.</i>   |  |   |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><i>Md.</i>   |                        | 13b COUNTY<br><i>Montgomery</i>  |  | 13c CITY OR TOWN<br><i>Sandy Springs</i>  |                                  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET AND NUMBER<br><i>17401 Norwood Road</i>  |
| 14 FATHER'S NAME<br>First <i>Joseph</i> Middle <i>R.</i> Last <i>Thomas</i>   |                        |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Alice</i> Middle <i>G.</i> Last <i>Jawcett</i>                                      |   |                                  |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>   |                        | 16b SOCIAL SECURITY NO<br>(If yes give year or dates of service)<br><i>---</i>                         |  | 17 INFORMANT<br><i>Frank J. Thomas</i>  |                                  | ADDRESS<br><i>3278 Glenaeles Dr. S.S. Md.</i>  |  |   |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost? <i>---</i><br>(b) <i>---</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>---</i><br>(c) <i>---</i>                 |                        |  |  |   |                                  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                        |  |  |   |                                  |  |  |   |
| 19a DATE OF OPERATION   |                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |                                  | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                        | 21b TIME OF INJURY Month, Day, Year<br>HOUR A.M. <i>19</i> P.M.  |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |                                  |  |  |   |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                        | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |  | 21f LOCATION Street or RFD No   |                                  | City or Town   |  | County State  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |  |  |   |                                  |  |  |   |
| ACTUAL SIGNATURE<br><i>Belden R. Reap</i>   |                        | EXAMINER'S NAME (Type)<br><i>KX Belden R. Reap M.D.</i>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                  | 22b. DATE SIGNED<br><i>Dec. 15, 1968</i>   |  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                        | 23b DATE<br><i>12-18-1968</i>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>Rock Creek Cemetery</i>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><i>Washington, D.C.</i>                       |  |   |
| 24. FUNERAL DIRECTOR<br><i>M. Andrew Dwyall, Warner E. Pumphrey, Inc. 8434 Georgia Ave.</i>   |                        |  |  | ADDRESS<br><i>Silver Spr. Md.</i>   |                                  | 25a REC'D BY REGISTRAR<br>DATE <i>DEC 23 1968</i>  |  | 25b REGISTRAR'S SIGNATURE<br><i>Charles J. J...</i> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 17978. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
17968  
17979  
CERTIFICATE OF DEATH

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 DECEASED-NAME (Type or print) <b>Eunice</b>  |  | First <b>B.</b> Middle <b>Thomas</b> Last   |  | 2a DATE OF DEATH <b>Dec</b> Month <b>22</b> Day <b>68</b> Year   |  | 2b HOUR <b>11:16</b> AM   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>3/1/92</b>   |  | 6 AGE (In years last birthday) <b>76</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Montgomery</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hosp.</b> |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |  |
| 13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <b>Maryland</b>   |  | 13b COUNTY <b>Montgomery</b>  |  | 13c CITY OR TOWN <b>Bethesda</b>   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e STREET AND NUMBER <b>9804 Montauk Avenue</b>   |  | 14 FATHER'S NAME First <b>William</b> Middle <b>Anadale</b> Last                                  |  | 15. MOTHER'S MAIDEN NAME First <b>Florence</b> Middle <b>Belfield</b> Last   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b SOCIAL SECURITY NO <b>None</b>  |  | 17 INFORMANT <b>A. Russell Thomas</b> Address <b>Same as #13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>332x</b><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 days</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>did and recent myocardial infarction</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)  |  |   |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 7, 1968</b> to <b>Dec 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 21, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Robert R. Montgomery, MD</b>   |  | 22c. DATE SIGNED <b>12/24/1968</b>  |  | 22d. PHYSICIAN'S NAME (Type) <b>ROBERT R. MONTGOMERY, MD</b>   |  |   |  |
| 22e. ADDRESS <b>5911 CEDAR LANE BETHESDA, MD</b>   |  | 23a. NAME OF CEMETERY OR CREMATORY <b>National Mem. Park Cem.</b>                                 |  | 23b. DATE <b>Dec. 26, 1968</b>   |  | 23c. LOCATION (City or Town) (County) (State) <b>Falls Church, Virginia</b>                 |  |
| 23d. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>  |  | 25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |  | 17980  |
|--|--|--|--|---|---|---|--|--|--|--|
| 1 DECEASED-NAME (Type or print)  |  |  |  |   | 2a. DATE OF DEATH   |   |  |  |  | 2b. HOUR                                     |
| First <i>KATHERINE</i> Middle <i>R</i> Last <i>THOMAS</i>  |  |  |  |   | Month <i>12</i> Day <i>7</i> Year <i>68</i>   |   |  |  |  | <i>7:00 AM</i>                               |
| 3 SEX <i>Female</i>  |  | 4 RACE <i>White</i>  |  | 5 DATE OF BIRTH <i>2-19-01</i>  |   |   | 6 AGE (In years last birthday) <i>67</i> YRS                         |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |
| 7a BIRTHPLACE (State or foreign country) <i>New Jers.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <i>Montgomery</i> Md.                                    |  |  |  |  |
| 10 CITY OR TOWN OF DEATH <i>Silver Spring</i>  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i> |  |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>                         |   |  | 12b KIND OF BUSINESS OR INDUSTRY <i>own home</i> |  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>New Jersey</i> COUNTY <i>Camden</i>  |  | 13b CITY OR TOWN <i>Camden</i>   |  | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET AND NUMBER <i>422 Grant Street</i>                               |  |  |  |  |
| 14. FATHER'S NAME First <i>Edward</i> Middle <i>--</i> Last <i>Rubright</i>  |  |  | 15. MOTHER'S MAIDEN NAME First <i>Lotti</i> Middle <i>--</i> Last <i>Hoffman</i> |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b SOCIAL SECURITY NO <i>150-10-4006</i>  |   | 17 INFORMANT Address <i>Edward H. Thomas 8308 26th Place, Adelphi, Md.</i>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))  |  |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>URINARY TRACT INFECTION</i> , <i>SEPSIS?</i>  |  |  |  |   |   |   |  |  |  | <i>2 weeks.</i>                              |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i>   |  |  |  |   |   |   |  |  |  | <i>&gt; 6 YEARS.</i>                         |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>DIABETES MELLITUS.</i>   |  |  |  |   |   |   |  |  |  | <i>6 YEARS.</i>                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>CORONARY HEART DISEASE, OLD MYOCARDIAL INFARCTIONS.</i>   |  |  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |   | 21f. LOCATION Street or R.F.D. No City or Town County State   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>October 16, 19 64</i> , to <i>December 7, 19 68</i> , that (I) (we) last saw the deceased alive on <i>December 7, 19 68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE <i>Hugo G. Graziani</i> MD. DEGREE  |  |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <i>12/7/68</i>                                      |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>HUGO G. GRAZIANI</i>   |  |  |  |   | 22e. ADDRESS <i>10101 GEORGIA AVENUE, SILVER SPRING, MD.</i>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 23b. DATE <i>12-11-1968</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Beth El Memorial Park</i>   |   | 23d. LOCATION (City or Town) (County) (State) <i>Pennsauken, New Jersey</i> |  |  |  |  |
| 24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>   |  |  |  |   | ADDRESS <i>Sil. Spr., Md.</i>   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>        |  |
|  |  |  |  |   | DATE <i>DEC 12 1968</i>   |   |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17981

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8811 Colsonville Road #106</b>  |  | d. STREET ADDRESS <b>8811 Colsonville Rd #106</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>CHARLES HENRY THOMPSON</b>   |  | 4. DATE OF DEATH <b>Dec. 15 1968</b>   |  |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>MAY 12, 1892</b>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATT. AT LAW</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>TALBOT CO., Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>JOHN P. Thompson</b>   |  | 14. MOTHER'S MAIDEN NAME <b>ETHEL L. BOONE</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>212-01-7276</b>   |  |
| 17. INFORMANT <b>MARGARET Thompson-Wife</b>   |  | Address <b>8811 Colsonville Rd</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO (b) <b>Arterio-sclerotic heart disease</b><br>DUE TO (c) <b>Arteriosclerosis - generalized</b>    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>1 year</b><br><b>5 years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1967</b> to <b>Dec 15, 1968</b> , that (I) (the) last saw the deceased alive on <b>Dec 13, 1968</b> , and that death occurred at <b>8:00 AM</b> , from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE <b>Harry N. Carlton</b> M.D.   |  | 22b. DATE SIGNED <b>Dec 15, 1968</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>HARRY N. CARLTON</b>  |  | 22d. ADDRESS <b>8811 Colsonville Rd, SS, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>12-17-1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave. N.W., Wash., D.C., 20016</b>  |  | 25a. REC'D BY REGISTRAR <b>DEC 19 1968</b>   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                          |

Handwritten text on a rectangular label, possibly a piece of tape or a small card, oriented horizontally. The text is written in cursive and appears to be a list or a set of instructions. The label is placed on a light-colored, textured background. The text is difficult to read due to the cursive style and the quality of the scan.

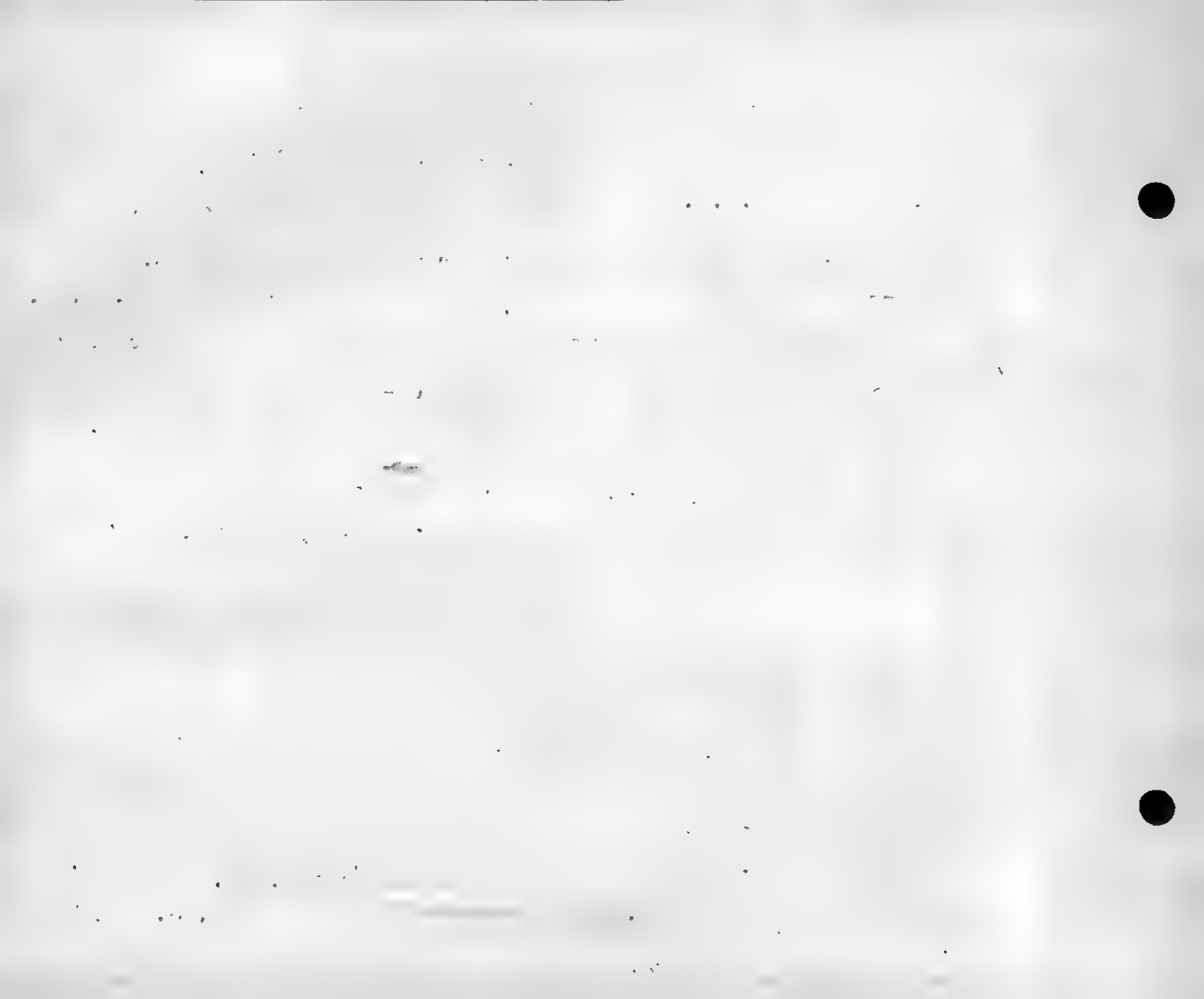
Handwritten text on a rectangular label, possibly a piece of tape or a small card, oriented horizontally. The text is written in cursive and appears to be a list or a set of instructions. The label is placed on a light-colored, textured background. The text is difficult to read due to the cursive style and the quality of the scan.



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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |  |  |
|---|--|--|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |  |
| 17982   |  |  |  |   |   |   |  |  |  |
| 1 DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |
| Claudia   |  |  | Thomson  |   |   | 12 Month 10 Day 68 Year   |  |  | 11:10 AM                                     |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (n years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| Female  |  | White  |  | May 7, 1986   |   | 87 YRS  |  |  |  |
| 7a BIRTHPLACE (State or foreign country)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |  |
| So. Dakota  |  | U.S.A.   |  |   |   | Montgomery Co. Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| SILVER SPRING   |  |  | CHEVY CHASE NURSING & CON. CENTER  |   |   | Agriculture Dept. GOVERNMENT  |  |  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b COUNTY   |   | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?   | 13e STREET AND NUMBER  |  |  |
| --  |  |  |  |   | Washington  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | 1636 Kenyon St. N. W.  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |  |  |
| First Middle Last   |  |  | First Middle Last  |   |   |   |  |  |  |
| Thomas Thomson  |  |  | Eli Engebretsen  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b SOCIAL SECURITY NO   |   | 17 INFORMANT Address  |   |  |  |  |
| Yes, no, or unknown   |  |  |  |   | decodent -  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |  |  |
| IMMEDIATE CAUSE (a) Pneumonia   |  |  |  |   |   |   |  |  | 48 hrs.                                      |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Disease   |  |  |  |   |   |   |  |  | Years  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis generalized   |  |  |  |   |   |   |  |  | Years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | City or Town  |  | County State                             |  |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | Street or R.F.D. No.  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 8, 1967, to date, 1968, that (I) (we) last saw the deceased alive on Nov-29-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                         |  |
| George G. Ball  |  |  |  |   |   |   |  | Dec 10, 1968                             |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS  |   |   |  |  |  |
|   |  |  |  | 7936 Old Georgetown Rd. Bethesda, Md.   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |  | (County) (State)                         |  |
| Removal   |  | 12/11/68   |  | Mountain View Cemetery  |   | Rapid City, S. Dakota   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE               |  |
| The H.H. Himes Co.  |  |  |  | 2901 14th ST. NW  |   | DEC 16 1968   |  | Charles Judge                            |  |

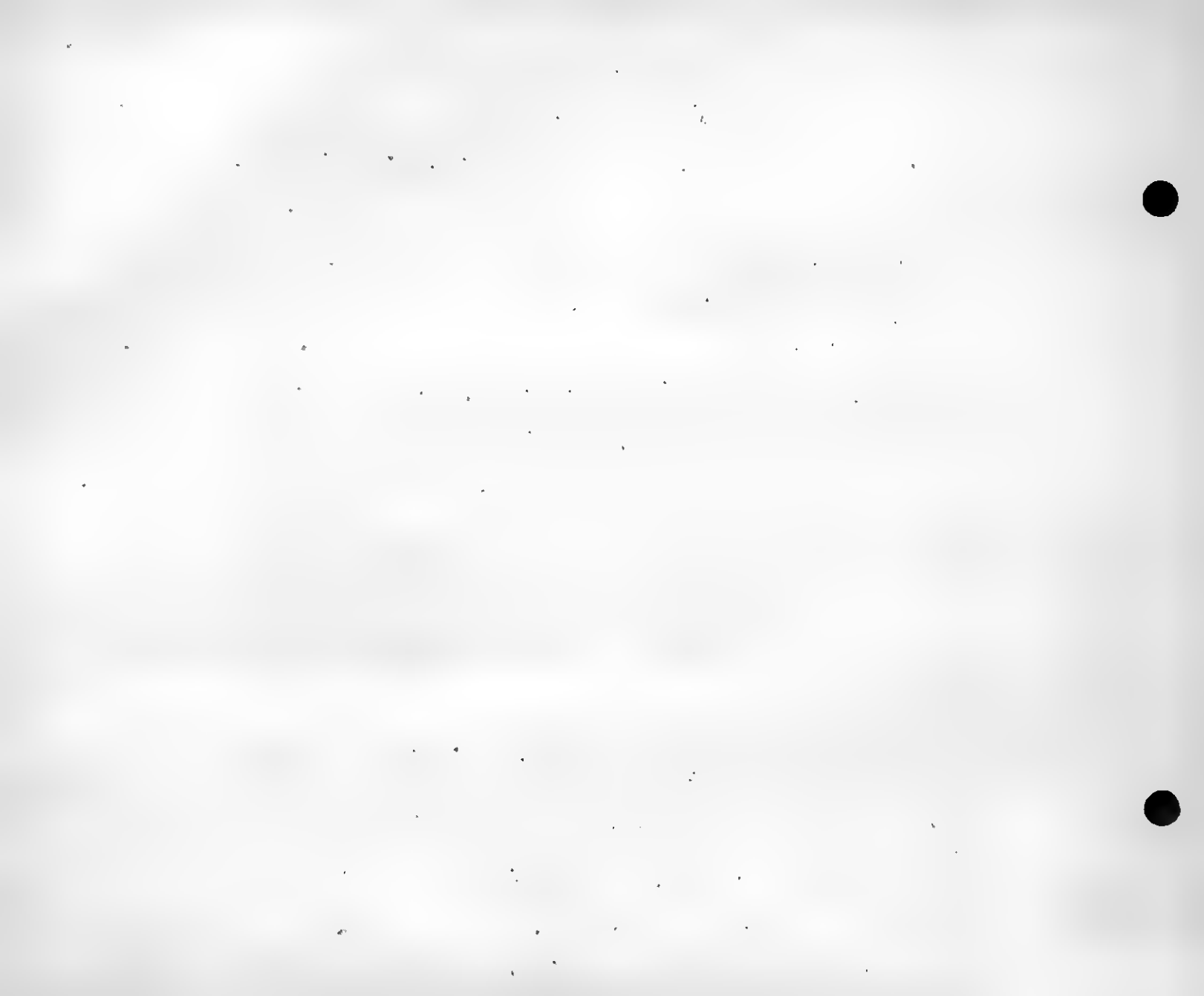


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VR A15 (4-68)  
30M REV. 1-78

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |                       |  |
|--|--|--|--|--|--|--|--|-----------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |                       |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                       |  |
| 17983  |  |  |  |  |  |  |  |                       |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |                       | 2b. HOUR                                     |
| Annie Viola Titus  |  |  |  |  |  | Month Day Year   |  |                       | M  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (in years last birthday)  |  | IF UNDER 1 YEAR       |  |
| Female   |  | White  |  | Dec. 18-1877   |  | 90 YRS.  |  | MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                       |  |
| Virginia   |  | US   |  |  |  | Montgomery Md  |  |                       |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |                       | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Poolesville  |  |  |  |  |  | None   |  |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       | 13e. STREET AND NUMBER                       |
| Maryland   |  |  | Montg.   |  | Poolesville  |  |  |                       |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |                       |  |
| First Middle Last  |  |  | First Middle Last  |  |  |  |  |                       |  |
| William Frye   |  |  | Annie Bales  |  |  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |  | Address  |                       |  |
| No   |  |  | 315-54-7420  |  | Mrs Betty Titus  |  | Poolesville, Md  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |                       |  |
| IMMEDIATE CAUSE (a) Cerebrovascular Accident   |  |  |  |  |  |  |  |                       | 5 days                                       |
| 4067 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |                       |  |
| (b) Atherosclerosis, Generalized   |  |  |  |  |  |  |  |                       | years  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |                       |  |
| (c)  |  |  |  |  |  |  |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |                       |  |
| 331X   |  |  |  |  |  |  |  |                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                       |  |
|  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                       |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |                       |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                       |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 13 April, 1959, to 7 Dec, 1968, that (I) (we) saw the deceased alive on 6 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death |  |  |  |  |  |  |  |                       |  |
| 22b. SIGNATURE   |  |  |  |  | 22c. DATE SIGNED   |  |  |                       |  |
| John Murdoch Smith MD  |  |  |  |  | 7 Dec 68   |  |  |                       |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS   |  |  |                       |  |
| Gordon Murdoch Smith, MD   |  |  |  |  | Barnesville, Md 20703                                    |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                       |  |
| Burial   |  | 12/19/68   |  | Monocacy   |  | Poolesville Montg Md   |  |                       |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25a. REC'D BY REGISTRAR                                  |  | 25b. REGISTRAR'S SIGNATURE   |                       |  |
| William D. Hilton, Barnesville Md  |  |  |  |  | DEC 11 1968  |  | Charles Judge  |                       |  |



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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |                                       |   |  |  |  |  |  | 17984 |
|--|--|---|---------------------------------------|---|--|--|--|--|--|-------|
| CERTIFICATE OF DEATH   |  |   |                                       |   |  |  |  |  |  |       |
| 1. DECEASED-NAME<br>(Type or print) <u>Tofsky Jacob</u>  |  |   | First Middle Last                     |   | 2a. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>14</u> Year <u>68</u>                  |  |  | 2b. HOUR<br><u>9:15 A.</u>                             |  |       |
| 3. SEX<br><u>M</u>   |  | 4. RACE<br><u>W.</u>  |                                       | 5. DATE OF BIRTH<br><u>12/13/1907</u>   |  | 6. AGE (In years last birthday)<br><u>78</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN               |  |       |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Russia</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Montgomery Co.</u> Md.  |  |  |  |       |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring, Md.</u>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Holy Cross</u> |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><u>BUYER (RETAIL)</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>CLOTHING</u>   |  |  |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Md.</u>  |  | 13b. COUNTY<br><u>Montg.</u>  |                                       | 13c. CITY OR TOWN<br><u>Rockville</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER<br><u>10401 Grosvenor Place</u> |  |       |
| 14. FATHER'S NAME<br><u>JACOB</u>  |  |   | First Middle Last<br><u>N. TOFSKY</u> |   | 15. MOTHER'S MAIDEN NAME<br><u>LEAH</u>  |  |  |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>075-20-7525</u>  |                                       | 17. INFORMANT<br><u>SON IRVING TOFSKY SAME HO 12</u>  |  | Address  |  |  |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u><br><u>4129</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CARDIAL ARRHYTHMIA - CORONARY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>MINUTES</u><br><u>2 YEARS</u><br><u>2-3 YRS +</u> |  |   |                                       |   |  |  |  |  |  |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201 NONE</u>  |  |   |                                       |   |  |  |  |  |  |       |
| 19a. DATE OF OPERATION<br><u>—</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>—</u>                                      |                                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>—</u> |  |  |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month—Day Year<br>P.M. 19 <u>68</u>                              |                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><u>—</u>   |  |  |  |  |  |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><u>—</u>          |                                       | 21f. LOCATION Street or R.F.D. No City or Town County State<br><u>—</u>   |  |  |  |  |  |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>68</u> , to <u>DEC 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>DEC 13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                                       |   |  |  |  |  |  |       |
| 22b. SIGNATURE<br><u>F.C. Mayle</u>  |  |   |                                       | DEGREE<br><u>MD</u>   |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>DEC 14 1968</u>                 |  |       |
| 22d. PHYSICIAN'S NAME (Type)<br><u>F.C. MAYLE MD</u>   |  |   |                                       | 22e. ADDRESS<br><u>6218 WISCONSIN AVE BETHESDA MD 20814</u>   |  |  |  |  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>12-16-68</u>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><u>NATHL MEM. PARK</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>FALLS CHURCH VA</u>  |  |  |  |       |
| 24. FUNERAL DIRECTOR<br><u>GOLDBERG FUNERAL HOME 4217 9TH ST. N.W.</u>   |  |   |                                       | ADDRESS<br><u>—</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 23 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Judge</u>    |  |       |



4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |  |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(Type or print) <i>Agnes B. Tucker</i>   |  |   | First <i>B.</i> Middle <i>Tucker</i> Last  |  |  | 2a. DATE OF DEATH<br>Month <i>12</i> - Day <i>19</i> - Year <i>68</i>  |  |  | 2b. HOUR<br><i>7:00</i> M  |  |  |   |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>2-3-94</i>  |  | 6 AGE (In years last birthday)<br><i>74</i> YRS  |  | F. UNDER 1 YEAR<br>MONTHS DAYS                                       |  | I. UNDER 24 HRS<br>HOURS MIN   |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Penna.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                               |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><i>Montgomery</i> Md  |  |  |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Bethesda</i>  |  |   | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><i>Suburban Hospital D.O.A.</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Retired</i>                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Homemaker</i>                                      |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE<br><i>Md.</i>   |  |   | 13b. COUNTY<br><i>Montgomery</i>   |  |  | 13c. CITY OR TOWN<br><i>Bethesda</i>   |  |  | 13d. WIDE CITY LHM 15? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  | 13e. STREET AND NUMBER<br><i>8710 Lowell Street</i> |  |
| 14 FATHER'S NAME<br><i>James Boner</i>   |  |   | First <i>James</i> Middle <i>Boner</i> Last  |  |  | 5 MOTHER'S MAIDEN NAME<br><i>Frances Harrison</i>  |  |  | First <i>Frances</i> Middle <i>Harrison</i> Last   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <i>No</i> (If yes give year or dates of service) <i>****</i>   |  |   | 16b. SOCIAL SECURITY NO<br><i>579-60-4458</i>  |  |  | 17 INFORMANT<br><i>Mrs Nancy Gilfrich</i>  |  |  | Address<br><i>8710 Lowell St.</i>  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Right sided cardiac failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <i>pulmonary emphysema</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr</i><br><i>yr</i> |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>52</i>  |  |   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>           |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY)<br>(OFFICE BUILDING ETC) |  | 21f. LOCATION Street or RFD No. City or Town County State  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 15, 1968</i> , to <i>Dec 11, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 17, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death                                   |  |   |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Alfred S. Norton</i> M.D. DEGREE  |  |   |  |  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>Dec 20 1968</i>                               |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>ALFRED S. NORTON, M.D.</i>  |  |   |  |  |  | 22e. ADDRESS<br><i>7710 Dwight Dr. Bethesda, Md. 20014</i>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><i>12/23/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Rockville, Montg. Md.</i>  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>  |  | 7557 Wisconsin Ave  |  | 25a. REC'D BY REGISTRAR<br><i>DEC 26 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |  |  |   |  |



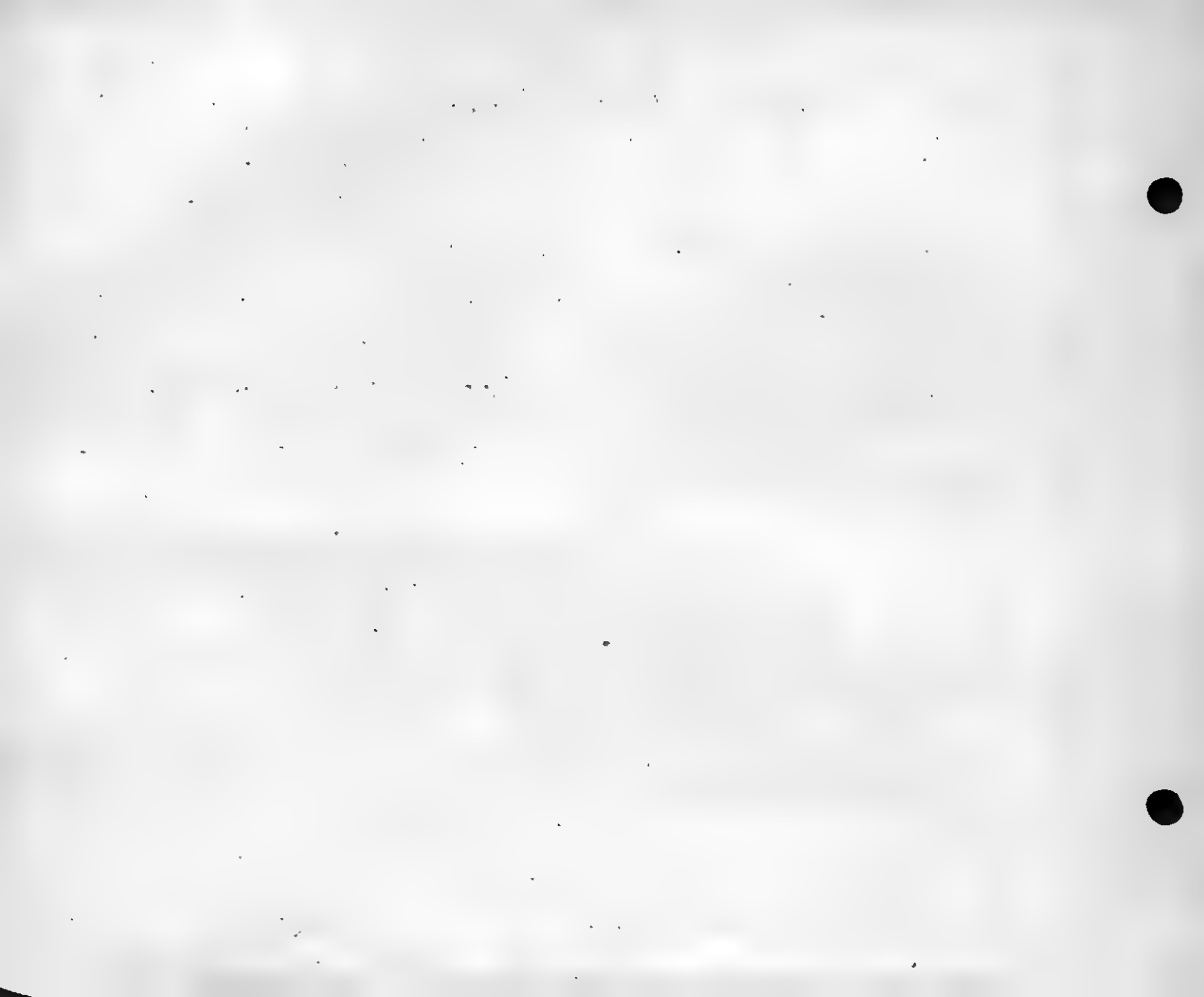


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VR A15  
30M REV 1/68

| 17975  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |  |  |  |  |  |  |  |  |  | 17985   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| KATHRYNNE MARIA UNKLE  |  |  |  |  |  |  |  |  |  | Month 12 Day 27 Year 1968  |  |  |  |  |  |  |  |  |  | 7:00 PM   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 3. SEX FE  |  |  |  |  |  |  |  |  |  | 4 RACE WHITE   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH 6-25-1899  |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) 69 YRS.                              |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS HOURS MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  |  |  |  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH MONTGOMERY Md.                                    |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP. |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Wash. D.C. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN Wash. D.C.   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER 3015 CHANNING ST. N.E.                        |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last JOHN - BEALL   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last MARGARET - BROWN  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO  |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address Marian Miller, R.N. Wash. San. Hosp.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 Subarachnoid hemorrhage  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | Minutes   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |  |  | (b) Atherosclerosis  |  |  |  |  |  |  |  |  |  | Minutes   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | (c) Exact interdictum  |  |  |  |  |  |  |  |  |  | Hours   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Days  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 12/23/68  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aneurysm of left                                    |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1968, to 12/27, 1968, that (I) (we) last saw the deceased alive on 12/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Kenneth Cruz M.D.   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 12/27/68  |  |  |  |  |  |  |  |  |  | 22d. PHYSICIAN'S NAME (Type) KENNETH CRUZ   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 853 University Blvd E. Silver Spring Md                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE 12-31-1968   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Luitland B. Hill Md    |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR R.A. Mattingly  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR 131-11th St. SE.   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge  |  |  |  |  |  |  |  |  |  | 25c. DATE JAN 2 1969   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |



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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |   |  |   |                                   |  |
|---|--|--|---|--|---|--|---|-----------------------------------|--|
| Item 23 Film 408 1/3/69 kk  |  |  |   |  |   |  |   |                                   |  |
| CERTIFICATE OF DEATH 17987  |  |  |   |  |   |  |   |                                   |  |
| 1 DECEASED NAME<br>(Type or print)  |  |  | First Middle Last   |  |   | 2a DATE OF DEATH   |   | 2b HOUR                           |  |
| ALICE   |  |  | M. VALLARIO   |  |   | DEC Month 18 Day 1968  |   | 1007 PM                           |  |
| 3 SEX   |  | 4 RACE   |   | 5 DATE OF BIRTH  |   | 6 AGE (In years lost birthday)   |   | 7c UNDER 1 YEAR                   |  |
| FEMALE  |  | CAUCASIAN  |   | FEB 11, 1920   |   | 48 YRS   |   | MONTHS DAYS HOURS MIN             |  |
| 7a BIRTHPLACE (State or foreign country)  |  | 7b CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |                                   |  |
| PENNSYLVANIA  |  | USA  |   |  |   | MONTGOMERY   |   |                                   |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during life, even if retired) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BETHESDA  |  |  | NAVAL HOSPITAL  |  |   | HOUSEWIFE  |   |                                   |  |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |  | 13b CITY OR TOWN  |  | 13d INSIDE CITY, M.T.S?   |  | 13e STREET AND NUMBER   |                                   |  |
| VIRGINIA  |  |  | ALEXANDRIA  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4639 RALEIGH AVENUE   |                                   |  |
| 14 FATHER'S NAME  |  |  | 15 MOTHER'S MAIDEN NAME   |  |   |  |   |                                   |  |
| First Middle Last   |  |  | First Middle Last   |  |   |  |   |                                   |  |
| THOMAS J. FLYNN   |  |  | ELIZABETH OWENS   |  |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |  | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT  |  |   |                                   |  |
| NO  |  |  | --  |  | (HUSBAND) MICHAEL E. VALLARIO ALEXANDRIA, VA.                       |  |   |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Carcinoma Ovary with Metastases</b><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |   |  |   |  |   |                                   |  |
| MEDICAL CERTIFICATION   |  |  |   |  |   |  |   |                                   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|   |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |   |                                   |  |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                  |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |                                   |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) |   | 21f LOCATION Street or R.F.D. No City or Town County State   |   |  |   |                                   |  |
|   |  |  |   |  |   |  |   |                                   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPT 29, 1968, to DEC 18, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC 18, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |   |  |   |                                   |  |
| 22b SIGNATURE   |  | DEGREE   |   | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                    |   | 22c DATE SIGNED  |   |                                   |  |
| J. G. Fleming   |  |  |   |  |   | 19 DEC 1968  |   |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e ADDRESS  |   |  |   |  |   |                                   |  |
| J. G. Fleming (M.D.)  |  | NAVAL HOSPITAL, BETHESDA, MARYLAND   |   |  |   |  |   |                                   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b DATE   |   | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION (City or Town) (County) (State)                           |   |                                   |  |
| BURIAL  |  | 12/24/68   |   | CATHEDRAL CEMETERY   |   | SCRANTON PENNSYLVANIA  |   |                                   |  |
| 24 FUNERAL DIRECTOR   |  | 24b ADDRESS  |   | 25a REC'D BY REGISTRAR   |   | 25b REGISTRAR'S SIGNATURE  |   |                                   |  |
| EVERLY-WHEATLEY   |  | 1500 WEST BRADDOCK Rd., ALEXANDRIA, VIRGINIA                               |   | DEC 24 1968  |   | J. Charles Judge   |   |                                   |  |

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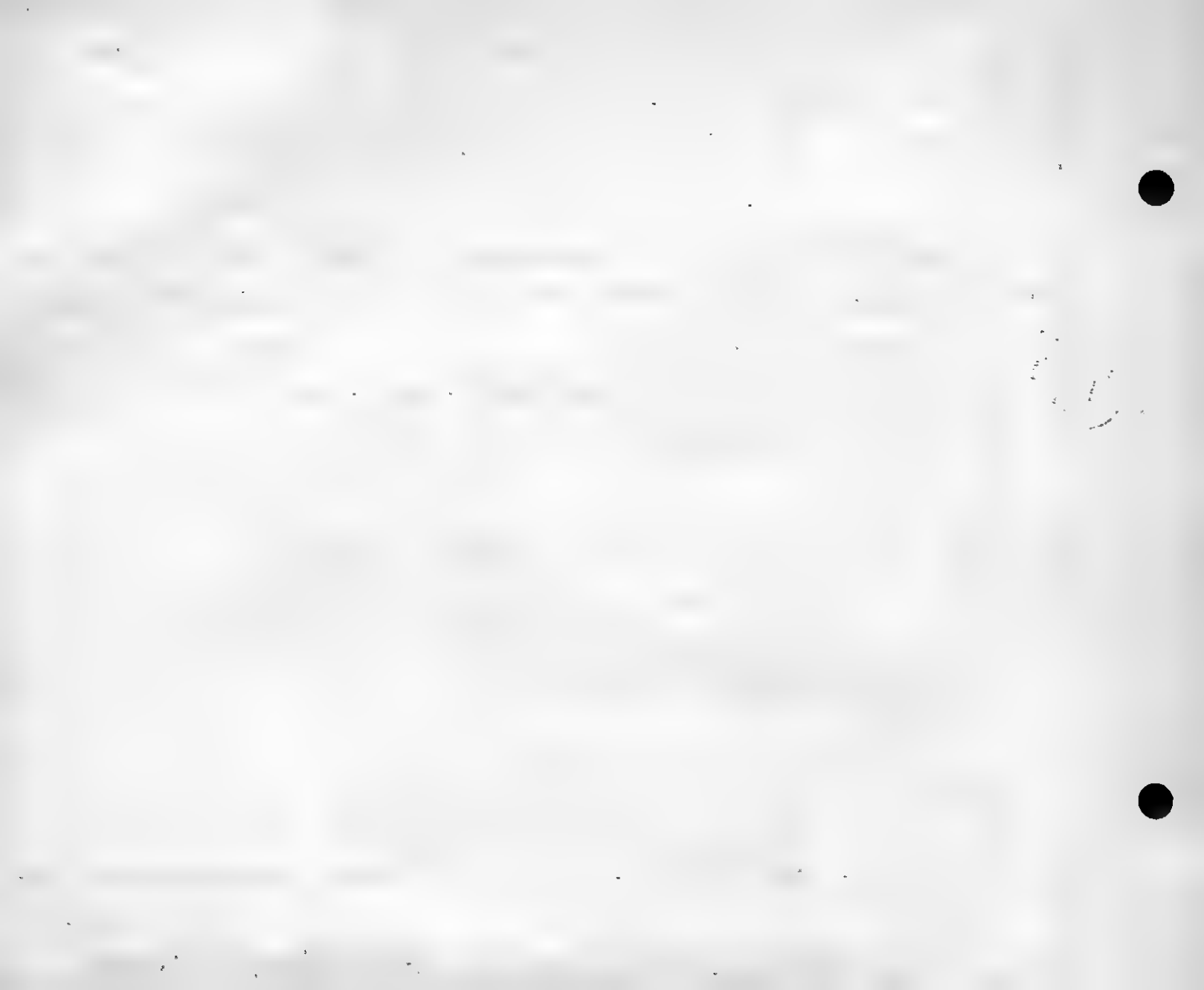
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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  | 17988                            |  |  |  |                           |  |
|--|--|--|--|---|--|---|--|--|--|----------------------------------|--|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(Type or print)  |  |  |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR                         |  |  |  |                           |  |
| First  |  | Middle   |  | Last  |  | Month   |  | Day  |  | Year                             |  | HOUR   |  |                           |  |
| HARRY  |  | J.   |  | VAN PELT  |  | 12  |  | 13   |  | 68                               |  | 4 P. M.                                      |  |                           |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  |   |  | 6 AGE (In years last birthday)                                       |  | IF UNDER 1 YEAR                  |  | IF UNDER 24 HRS                              |  |                           |  |
| Male   |  | White  |  | Nov. 11, 1898   |  |   |  | 70   |  | MONTHS                           |  | DAYS   |  |                           |  |
| 7a BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9 COUNTY OF DEATH  |  |                                  |  | Md.  |  |                           |  |
|  |  | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Montgomery   |  |                                  |  |  |  |                           |  |
| 10 CITY OR TOWN OF DEATH   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |  |   |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |  |  | 12b KIND OF BUSINESS OR INDUSTRY |  |  |  |                           |  |
| Silver Spring  |  | Holy Cross Hospital  |  |   |  | Manager   |  |  |  | Shoe Store                       |  |  |  |                           |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE  |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?   |  | 13e STREET AND NUMBER  |  |                                  |  |  |  |                           |  |
| Md.  |  | Montgomery   |  | Chevy Chase   |  | YES   |  | 2613 East-West Highway   |  |                                  |  |  |  |                           |  |
| 14. FATHER'S NAME  |  |  |  | 15 MOTHER'S MAIDEN NAME   |  |   |  |  |  |                                  |  |  |  |                           |  |
| First  |  | Middle   |  | Last  |  | First   |  | Middle   |  | Last                             |  |  |  |                           |  |
| Samuel   |  | P.   |  | Van Pelt  |  | -   |  | -  |  | -                                |  | -  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT  |  | Address   |  |  |  |                                  |  |  |  |                           |  |
| No   |  | 345-05-2497A   |  | Mrs. Mary K. Van Pelt   |  | 2613 East West Highway  |  |  |  |                                  |  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |  |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                           |  |
| PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a)  |  |  |  |   |  |   |  |  |  |                                  |  | Less than 1 day                              |  |                           |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
| (b) CORONARY ARTERY DISEASE  |  |  |  |   |  |   |  |  |  |                                  |  | YRS  |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
| (c) HYPERTENSIVE CARDIOVASC. DIS.  |  |  |  |   |  |   |  |  |  |                                  |  | YRS.   |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
| MEDICAL CERTIFICATION  |  |  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                  |  |  |  |                           |  |
|  |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | Yes  |  |                                  |  |  |  |                           |  |
| 21a ACCIDENT WAS UNDERLYING  |  | 21b TIME OF INJURY   |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |  |   |  |  |  |                                  |  |  |  |                           |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | HOUR A.M. Month Day Year   |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
|  |  | P.M. 19  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
| 21d INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) |  | 21f. LOCATION   |  |   |  |  |  |                                  |  |  |  |                           |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/>  |  |  |  | Street or R.F.D. No   |  |   |  | City or Town   |  |                                  |  |  |  |                           |  |
| at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |   |  |   |  | County   |  |                                  |  |  |  |                           |  |
|  |  |  |  |   |  |   |  | State  |  |                                  |  |  |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan, 1965, to 12/13, 1968, that (I) (we) last saw the deceased alive on 12/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |
| 22b. SIGNATURE   |  |  |  |   |  |   |  |  |  |                                  |  | 22c. DATE SIGNED                             |  |                           |  |
| G. Leonard Gold  |  |  |  |   |  |   |  |  |  |                                  |  | 12/13/68                                     |  |                           |  |
| 22d PHYSICIAN'S NAME (Type)  |  |  |  |   |  |   |  |  |  |                                  |  | 22e ADDRESS                                  |  |                           |  |
| G. Leonard Gold M.D.   |  |  |  |   |  |   |  |  |  |                                  |  | 9801 Georgia Avenue Silver Spring, Md.       |  |                           |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d LOCATION (City or Town)  |  | (County)                         |  | (State)                                      |  |                           |  |
| Burial   |  | 12-16-68   |  | Parklawn Cemetery   |  |   |  | Rockville  |  | Mont.                            |  | Md.  |  |                           |  |
| 24 FUNERAL DIRECTOR  |  |  |  |   |  |   |  |  |  |                                  |  | 25a REC'D BY REGISTRAR                       |  | 25b REGISTRAR'S SIGNATURE |  |
| M. Andrew Duwall   |  |  |  |   |  |   |  |  |  |                                  |  | DEC 19 1968                                  |  | Charles Judge             |  |
| Warner E. Pumphrey Inc. 8434 Ga. Avenue S.S.   |  |  |  |   |  |   |  |  |  |                                  |  |  |  |                           |  |



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| 17988  |                             | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201    |  |   |                                    | 17989  |   |
|--|-----------------------------|--|--|---|------------------------------------|--|---|
| CERTIFICATE OF DEATH   |                             |  |  |   |                                    |  |   |
| 1 DECEASED NAME<br>(Type or print)   |                             | First  | Middle   | Last  | 2a DATE OF DEATH<br>Month Day Year |  | 2b HOUR   |
| Hugo   |                             | D.   |  | Vechery   | December 19 68                     |  | 2:10 PM   |
| 3 SEX  | 4 RACE                      |  | 5 DATE OF BIRTH  |   | 6 AGE (In years<br>last birthday)  | 7 IF UNDER YEAR<br>MONTHS DAYS                                       |   |
| Male   | white                       |  | Sept 4. 1875   |   | 93                                 |  |   |
| 7a BIRTHPLACE (State or foreign<br>country)  | 7b CITIZEN OF WHAT COUNTRY? |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 COUNTY OF DEATH                  |  |   |
| Hungary  | Naturalized U.S.A.          |  |  |   | Montgomery                         |  |   |
| 10 CITY OR TOWN OF DEATH   |                             | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)                    |                                    | 12b KIND OF BUSINESS OR<br>INDUSTRY                                  |   |
| Silver Spring  |                             | Fairland Rd - Silver Spring, Md  |  | Maitre'd  |                                    | Restaurant   |   |
| 13a USUAL RESIDENCE (Where deceased lived, if institution on residence before<br>admission) STATE  |                             | 13b COUNTY   |  | 13c CITY OR TOWN  |                                    | 13d INSIDE CITY - JAN 1968   |   |
| MARYLAND   |                             | MONTGOMERY   |  | SILVER SPRING   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 14 FATHER'S NAME   |                             | 15 MOTHER'S MAIDEN NAME  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service) |                                    |  |   |
| Ignatius   |                             | FANNIE   |  | NO  |                                    |  |   |
| 16b SOCIAL SECURITY NO.  |                             | 17 INFORMANT   |  | Address   |                                    |  |   |
| 565-12-8708  |                             | FREDERIC D. VECHERY  |  | SAME AS # 13  |                                    |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |                             |  |  |   |                                    |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism &amp; Congestive failure.</u>   |                             |  |  |   |                                    |  | 1 day   |
| Conditions, if any, which gave rise to immediate cause (a) <u>fractured femur, acute bilateral</u>   |                             |  |  |   |                                    |  | 12 days   |
| stating the underlying cause last  |                             |  |  |   |                                    |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                             |  |  |   |                                    |  |   |
| <u>acute cerebral hemorrhage (CVA)</u>   |                             |  |  |   |                                    |  |   |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a. AUTOPSY?   |                                    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
|  |                             |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                             | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)                              |                                    |  |   |
|  |                             | 19   |  |   |                                    |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                             | 21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY)<br>OFFICE BUILDING, ETC   |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |                                    |  |   |
|  |                             |  |  |   |                                    |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-2-1968 to 12-19-1968, that (I) (we) last saw the deceased alive on 12-19-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                             |  |  |   |                                    |  |   |
| 22b. SIGNATURE <u>John R. Spencer, M.D.</u>  |                             |  |  | 22c. DATE SIGNED  |                                    | 12-19-68   |   |
| 22d. PHYSICIAN'S NAME (Type)   |                             |  |  | 22e. ADDRESS  |                                    |  |   |
| JOHN R. SPENCER, M. D.   |                             |  |  | 15444 COLUMBIA ROAD, BURTONTOWN, MD.  |                                    |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                             | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                    | 23d. LOCATION (City or Town) (County) (State)                        |   |
| Burial   |                             | 12-23-68   |  | FT LINCOLN CEMETERY   |                                    | BLADENSBURG MARYLAND.  |   |
| 24. FUNERAL DIRECTOR   |                             | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                                    |  |   |
| Francis Hall   |                             | DATE DEC 23 1968   |  | [Signature]   |                                    |  |   |





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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |
| 17990   |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print) <b>MABEL</b>  |  |  | First Middle Last <b>MCKIM VEIHMAYER</b>                           |   |  | 2a. DATE OF DEATH<br>12 Month 28 Day 68 Year   |  | 2b. HOUR<br>1:55 A.M.                              |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>11-26-86</b>   |  | 6. AGE (in years last birthday)<br><b>82</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>FAIRLAND NURSING HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>HOUSEKEEPER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)<br>STATE <b>MD</b>  |  | 13b. COUNTY<br><b>MONT</b>   |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>14221 GEORGIA AVE</b> |  |
| 14. FATHER'S NAME<br>First Middle Last <b>JOSHUA GIBSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last <b>ANNIE B. MEAD</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO<br><b>213-54-8613</b>                      |   | 17. INFORMANT<br><b>NURSING HOME SUMMARY SHEET</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>480x</b><br>(b) <b>Influenza</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |  |  |  | <b>1 wk</b><br><br><b>2 wks</b>              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Generalized and Cerebral ARTERIOSCLEROSIS</b>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION<br>Street or R.F.D. No City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> , to <b>Dec 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Raymond T. Benack MD</b>   |  |  |  |   | DEGREE<br>ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12/28/68</b>                                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Raymond T. Benack MD</b>   |  |  |  |   | 22e. ADDRESS<br><b>4115 Colie DR. Wheaton, Md</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/31/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Maryland</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home 1331 Rock. Pike</b>   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 3 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |  |   |                                       |   |  |
|---|--|---|--|--|---|--|---|---------------------------------------|---|--|
| Item 5 Film 408 1/13/69 kk  |  |   |  |  | CERTIFICATE OF DEATH  |  |   |                                       |   |  |
| 1. DECEASED NAME<br>(Type or print) First Middle Last<br>Galina (NMN) Volkov  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>December 27 1968  |  |   | 2b. HOUR<br>1:50 M   |   |                                       |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>1927 1929 26 January 1929  |   | 6 AGE (years last birthday)<br>41 YRS.   |   | F UNDER 1 YEAR<br>MONTHS DAYS<br>11 1 |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 COUNTY OF DEATH<br>Montgomery Md   |   |                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |   | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>The Clinical Center |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY     |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) - STATE<br>Maryland  |  |   | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Bethesda   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       | 13e. STREET AND NUMBER<br>6301 Crathie Lane             |  |
| 14 FATHER'S NAME First Middle Last<br>Vladimir Tzvetekoff   |  |   | 15 MOTHER'S MAIDEN NAME First Middle Last<br>Elizabeth (Unknown)                                   |  |   |  |   |                                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) No  |  |   | 16b. SOCIAL SECURITY NO<br>None  |  | 17 INFORMANT The Medical Records Address<br>The Clinical Center, NIH, Bethesda, Md. 20014                                       |  |   |                                       |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hodgkin's Disease involving lymph nodes, heart/<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |  |   |  |   |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 Years |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                        |                                       |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)   |   |  |   |                                       |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |  | 21f. LOCATION Street or R.F.D. No City or Town County State  |   |  |   |                                       |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 25 Dec. 1968, to 27 Dec. 1968, that (X) (we) last saw the deceased alive on 27 December 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death   |  |   |  |  |   |  |   |                                       |   |  |
| 22b. SIGNATURE<br>Ervin H. Epstein, MD. DEGREE  |  |   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>27 December 1968  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Ervin H. Epstein, MD.   |  |   |  |  | 22e. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014   |  |   |                                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>12-30-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rock Creek   |   | 23d. LOCATION (City or Town) (County) (State)<br>Washington, D.C.                                    |   |                                       |   |  |
| 24 FUNERAL DIRECTOR<br>1545 Wisconsin Ave. Bethesda, Md.  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>JAN 6 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                                       |   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                          |  |  |  |
|---|--------------------------|--|--|--|
| 1 DECEASED NAME<br>(Type or Print) <b>MARY</b> First <b>ELIZABETH</b> Middle <b>WALLING</b> Last  |                          | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>12</b> Day <b>4</b> Year <b>1968</b>  |  | 2b HOUR <b>10:15</b> AM  |
| 3 SEX <b>FEMALE</b>   | 4 RACE <b>WHITE</b>      | 5 DATE OF BIRTH <b>May 3, 1925</b>   | 6 AGE (on years next birthday) <b>42</b> YRS   | 7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                          | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD Month <b>DEC</b> Day <b>4</b> Year <b>1968</b>                      |
| 10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>   |                          | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>housewife</b>   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                          | 13b. COUNTY <b>Mont.</b>   | 13c. CITY OR TOWN <b>SIL. SPR.</b>   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME First <b>Sam</b> Middle <b>Cook</b> Last  |                          | 15. MOTHER'S MAIDEN NAME First <b>Cora</b> Middle <b>Hardy</b> Last  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                          | 16b. SOCIAL SECURITY NO <b>577 09 2705</b>   |  | 17 INFORMANT <b>Son</b> ADDRESS <b>Thomas Walling, 405 Branch Rd. Vealeva Va</b>             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |                          |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                          |  |  |  |
| 19a. DATE OF OPERATION  |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                          | 21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b>PM</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                          | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No City or Town County State                                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                          |  |  |  |
| ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.   |                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED <b>DEC. 4 1968</b>  |
| EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>   |                          | ADDRESS (Type) <b>405 Branch Rd. Vealeva Va</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE <b>12/7/68</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Memo. Park Cem. Fairfax, Va. India</b>   |  | 23d. LOCATION (City or Town) (County) (State)  |
| 24. FUNERAL DIRECTOR <b>De Vol Funeral Home</b> ADDRESS <b>2222 Wis. Ave. N.W.</b>  |                          | 25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                             |   |   |  |   |   |                                  |  |  |
|---|--|-----------------------------|---|---|--|---|---|----------------------------------|--|--|
| CERTIFICATE OF DEATH  |  |                             |   |   |  |   |   |                                  |  |  |
| 1 DECEASED-NAME (Type or print)   |  |                             | First Middle Last   |   |  | 2a DATE OF DEATH  |   | 2b HOUR                          |  |  |
| John J. WALSH, SR.  |  |                             |   |   |  | December 10 1968  |   | 1000                             |  |  |
| 3 SEX   |  | 4 RACE                      |   | 5. DATE OF BIRTH  |  | 6 AGE (In years last birthday)  |   | 7 FINDER YEAR                    |  |  |
| Male  |  | Caucasian                   |   | 31 May 1895   |  | 73 YRS  |   | MONTHS DAYS HOURS MIN            |  |  |
| 7a BIRTHPLACE (State or foreign country)  |  | 7b CITIZEN OF WHAT COUNTRY? |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH   |   |                                  |  |  |
| Massachusetts   |  | USA                         |   |   |  | Montgomery Md   |   |                                  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                             | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   | 12b KIND OF BUSINESS OR INDUSTRY |  |  |
| Bethesda  |  |                             | Naval Hospital  |   |  | U. S. Navy  |   |                                  |  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE  |  |                             | 13b COUNTY  |   | 13c CITY OR TOWN                                       |   | 13d HOME CITY LIM TSP   |                                  | 13e STREET AND NUMBER                        |  |
| Maryland  |  |                             | Pr. George  |   | Adelphi  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 10121 Towhee Ave.                            |  |
| 14 FATHER'S NAME  |  |                             | 15. MOTHER'S MAIDEN NAME  |   |  |   |   |                                  |  |  |
| First Middle Last   |  |                             | First Middle Last   |   |  |   |   |                                  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                             | 16b SOCIAL SECURITY NO.   |   | 17 INFORMANT   |   |   |                                  |  |  |
| Yes   |  |                             | 1912-52   |   | Adelphia Md. Mr. John J. Walsh, Jr., 10121 Towhee Ave. |   |   |                                  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                             |   |   |  |   |   |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: PNEUMONIA RIGHT LOWER LOBE   |  |                             |   |   |  |   |   |                                  |  |  |
| IMMEDIATE CAUSE (a) 481X  |  |                             |   |   |  |   |   |                                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                             |   |   |  |   |   |                                  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                             |   |   |  |   |   |                                  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |                             |   |   |  |   |   |                                  |  |  |
| (c)   |  |                             |   |   |  |   |   |                                  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                             |   |   |  |   |   |                                  |  |  |
| 19a DATE OF OPERATION   |  |                             |   |   |  |   |   |                                  |  |  |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                             |   |   |  |   |   |                                  |  |  |
| 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                             |   |   |  |   |   |                                  |  |  |
| 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes   |  |                             |   |   |  |   |   |                                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                             |   |   |  |   |   |                                  |  |  |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |                             |   |   |  |   |   |                                  |  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |                             |   |   |  |   |   |                                  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |                             |   |   |  |   |   |                                  |  |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC  |  |                             |   |   |  |   |   |                                  |  |  |
| 21f. LOCATION Street or R.F.D. No City or Town County State   |  |                             |   |   |  |   |   |                                  |  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from Dec. 8, 1968, to Dec. 10, 1968, that (he) (we) last saw the deceased alive on Dec. 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                             |   |   |  |   |   |                                  |  |  |
| 22b. SIGNATURE  |  |                             |   |   |  |   |   |                                  |  |  |
| A. L. GRAYBIEL  |  |                             |   |   |  |   |   |                                  |  |  |
| 22c. DATE SIGNED  |  |                             |   |   |  |   |   |                                  |  |  |
| December 11, 1968   |  |                             |   |   |  |   |   |                                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                             |   |   |  |   |   |                                  |  |  |
| A. L. GRAYBIEL  |  |                             |   |   |  |   |   |                                  |  |  |
| 22e. ADDRESS  |  |                             |   |   |  |   |   |                                  |  |  |
| Naval Hospital, Bethesda, Md.   |  |                             |   |   |  |   |   |                                  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |  |                             |   |   |  |   |   |                                  |  |  |
| Burial  |  |                             |   |   |  |   |   |                                  |  |  |
| 23b DATE  |  |                             |   |   |  |   |   |                                  |  |  |
| 12/13/68  |  |                             |   |   |  |   |   |                                  |  |  |
| 23c NAME OF CEMETERY OR CREMATORY   |  |                             |   |   |  |   |   |                                  |  |  |
| Arlington National Cem.   |  |                             |   |   |  |   |   |                                  |  |  |
| 23d LOCATION (City or Town) (County) (State)  |  |                             |   |   |  |   |   |                                  |  |  |
| Arlington Va.   |  |                             |   |   |  |   |   |                                  |  |  |
| 24 FUNERAL DIRECTOR   |  |                             |   |   |  |   |   |                                  |  |  |
| Timothy Hanlow Funeral Home   |  |                             |   |   |  |   |   |                                  |  |  |
| 4748 Wisconsin Ave., N.W. Washington, D. C.   |  |                             |   |   |  |   |   |                                  |  |  |
| 25a RECD BY REGISTRAR   |  |                             |   |   |  |   |   |                                  |  |  |
| DATE DEC 16 1968  |  |                             |   |   |  |   |   |                                  |  |  |
| 25b REGISTRAR'S SIGNATURE   |  |                             |   |   |  |   |   |                                  |  |  |
| Charles Judge   |  |                             |   |   |  |   |   |                                  |  |  |





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VR AIS  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|-------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
| 17994   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
| 1 DECEASED NAME<br>(Type or print)  |  |  | First<br>Herbert   |  |  | Middle<br>E.  |  |  | Last<br>Walter   |  |  | 2a DATE OF DEATH<br>Month Day Year<br>Dec 28 1968 |  |  | 2b HOUR<br>6:45 AM            |  |  |
| 3 SEX<br>Male   |  |  | 4 RACE<br>White  |  |  | 5. DATE OF BIRTH<br>11/25/92  |  |  | 6 AGE (in years<br>last birthday)<br>76 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  |  | IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a BIRTHPLACE (State or foreign<br>country)<br>West DC  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                     |  |  | 9. COUNTY OF DEATH<br>Montgomery   |  |  |   |  |  |                               |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Shirley Hospital |  |  | 12a US.A. OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>RETIRED  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>N/A  |  |  |   |  |  |                               |  |  |
| 13a USUAL RESIDENCE (Where deceased<br>admission) STATE<br>West DC  |  |  | 13b COUNTY<br>—  |  |  | 13c CITY OR TOWN<br>DC  |  |  | 13d INS. DE. CITY, J.M. 19?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e STREET AND NUMBER<br>5437 COUN. AVE., N.W.    |  |  |                               |  |  |
| 14 FATHER'S NAME<br>First Middle Last<br>John L. Walter   |  |  | 15 MOTHER'S MAIDEN NAME<br>First Middle Last<br>Emma S. Parsons                                    |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Army NW 577-01-8400 |  |  | 16b SOCIAL SECURITY NO<br>577-01-8400  |  |  | 17 INFORMANT<br>Sister Edna Walter Same address   |  |  |                               |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Myocardial Decomp with pulmonary & peripheral edema 6 wks<br>492X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pulmonary emphysema, very severe 10 yrs +<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>last 1/2 yr |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |                               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Uremia secondary to (a) and arteriosclerosis  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                            |  |  |   |  |  |                               |  |  |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1968  |  |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |  |                               |  |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY (At home farm street factory)<br>(Office building etc)                         |  |  | 21f LOCATION Street or RFD No. City or Town County State  |  |  |  |  |  |   |  |  |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1958 to Dec 27, 1968, that (I) (we) last<br>saw the deceased alive on Dec 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
| 22b SIGNATURE<br>Stewart Clapp M.D.   |  |  | DEGREE<br>M.D.   |  |  | ATTENDING<br>PHYS <input checked="" type="checkbox"/> MED<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS <input type="checkbox"/>   |  |  | 22c DATE SIGNED<br>12/27/68  |  |  |   |  |  |                               |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Stewart Clapp M.D.   |  |  | 22e ADDRESS<br>5415 W Cedar Lane<br>Bethesda, Md.  |  |  |   |  |  |  |  |  |   |  |  |                               |  |  |
| 23a BURIAL, CREMATION<br>REMOVAL (Specify)<br>BURIAL  |  |  | 23b DATE<br>12/31/68   |  |  | 23c NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CEMETERY  |  |  | 23d LOCATION (City or Town) (County) (State)<br>SUITLAND, MD.                                      |  |  |   |  |  |                               |  |  |
| 24. FUNERAL DIRECTOR<br>JOS. GAWLER'S SONS, 5130 WIS. AVE., NW, WASH., D.C.   |  |  | 25a. REC'D BY REGISTRAR<br>DATE JAN 2 1969   |  |  | 25b REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |  |  |  |   |  |  |                               |  |  |

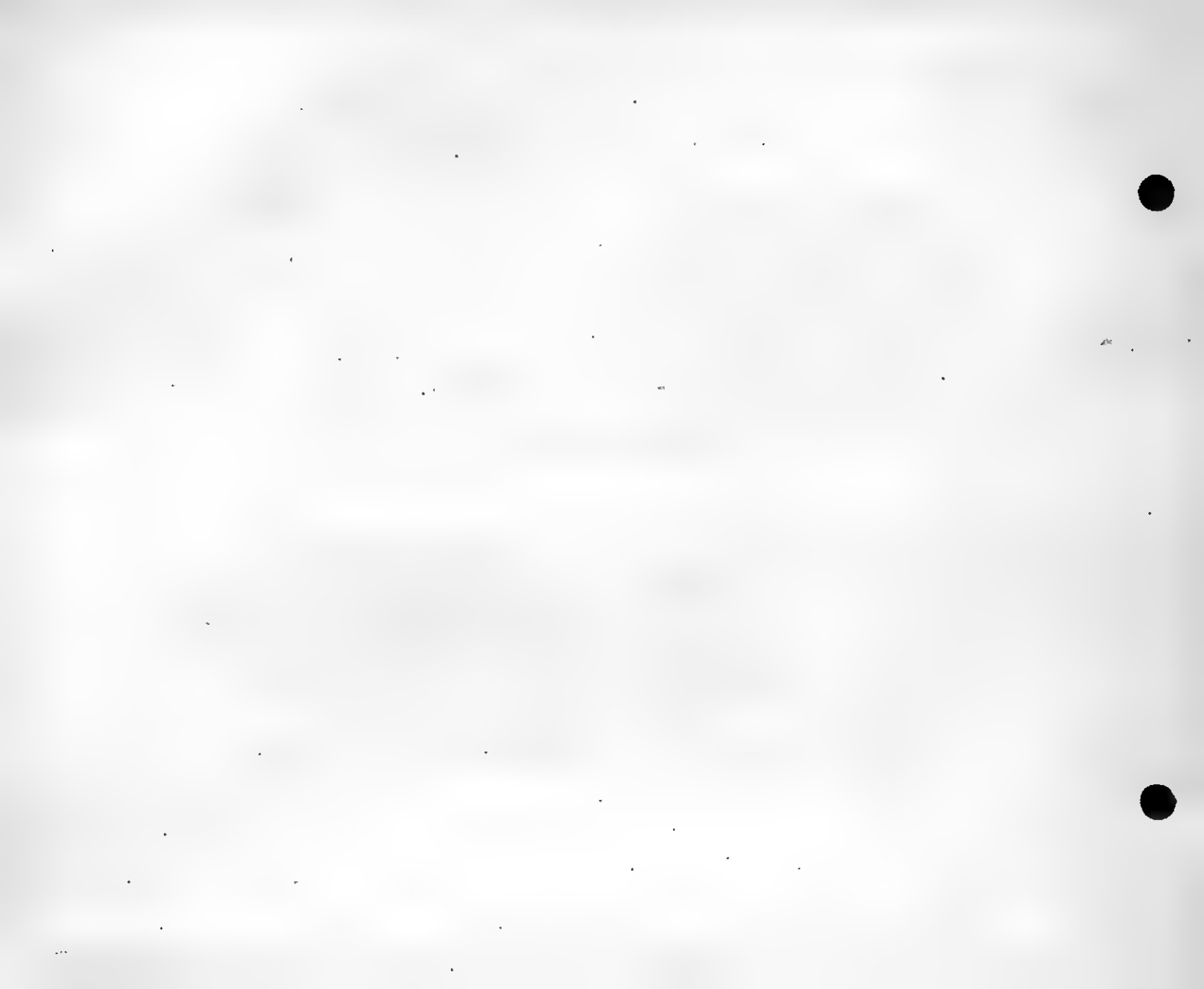
MEDICAL CERTIFICATION



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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| 17995   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| Item 6 Film 408 1/2/69 kk   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| 1 DECEASED NAME<br>(Type or print)  |  |  | First<br><b>Mary</b>   |  |  | Middle<br><b>G.</b>  |  |  | Last<br><b>WALTERS</b>   |  |  | 2a DATE OF DEATH<br>Dec. Month 18 Day Year 68  |  |  | 2b HOUR<br>946P M |  |  |
| 3 SEX<br><b>Female</b>  |  |  | 4 RACE<br><b>Caucasian</b>   |  |  | 5 DATE OF BIRTH<br><b>Apr. 29, 1915</b>  |  |  | 6 AGE (in years last birthday)<br><b>53</b> YRS  |  |  | F UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  | IF UNDER 24 HRS   |  |  |
| 7a BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 COUNTY OF DEATH<br><b>Montgomery</b>   |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |  |  |                   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Naval Hospital</b> |  |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Secretary</b>  |  |  | 13a STREET AND NUMBER<br><b>816 Veirs Mill Road</b>  |  |  | 13b INS. OF CITY, JIM TST<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                   |  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b COUNTY<br><b>Montgomery</b>  |  |  | 13c CITY OR TOWN<br><b>Rockville</b>   |  |  | 13d INS. OF CITY, JIM TST<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e STREET AND NUMBER<br><b>816 Veirs Mill Road</b>  |  |  |                   |  |  |
| 14 FATHER'S NAME<br>First Middle Last<br><b>William Francis Gettings</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Lillian McGaha</b>                                |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, No or unknown<br><b>No</b>   |  |  | 16b SOCIAL SECURITY NO<br><b>577-26-3213</b>   |  |  | 17 INFORMANT<br><b>Rockville Md.</b><br><b>William F. Walters 816 Veirs Mill Rd.</b>             |  |  |                   |  |  |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |                   |  |  |
| PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid and intraventricular hemorrhage</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>                |  |  |  |  |  |                   |  |  |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, nat'l medical examiner)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |                   |  |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)<br>OFFICE BUILDING, ETC.                        |  |  | 21f LOCATION Street or R.F.D. No City or Town County State   |  |  |  |  |  |  |  |  |                   |  |  |
| 22a I certify that (X) (this hospital) attended the deceased from <b>Nov. 27</b> , 19 <b>68</b> , to <b>Dec. 18</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>Dec. 18</b> , 19 <b>68</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |
| 22b SIGNATURE<br><i>John P. Wissinger</i>   |  |  | 22c DATE SIGNED<br><b>Dec. 19, 1968</b>  |  |  | 22d PHYSICIAN'S NAME (Type)<br><b>John P. Wissinger, M. D.</b>   |  |  | 22e ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |  |  |  |  |  |                   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b DATE<br><b>12/23/68</b>  |  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>ParkLawn Cemetery</b>  |  |  | 23d LOCATION (City or Town) (County) (State)<br><b>Rockville, Montgomery Md.</b>                 |  |  |  |  |  |                   |  |  |
| 24 FUNERAL DIRECTOR<br><b>Robert A. Pumphrey</b>  |  |  | 25a REC'D BY REG. STRAR<br><b>DEC 26 1968</b>  |  |  | 25b REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  | 25c ADDRESS<br><b>Funeral Home, 7557 Wisconsin Ave. Bethesda, Md.</b>                            |  |  |  |  |  |                   |  |  |



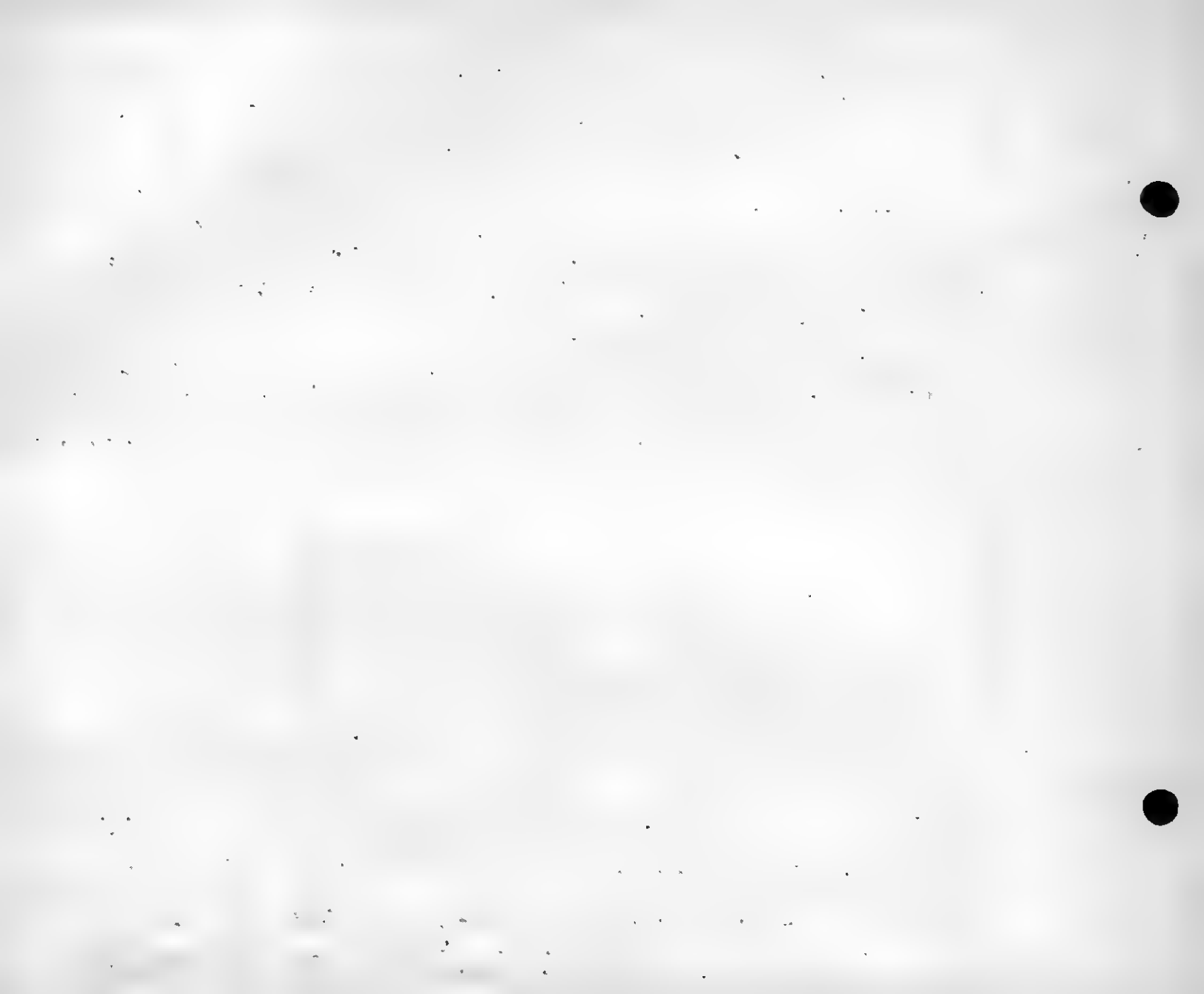
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VR 115  
30M REV 10

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |   |  |  |  |                               |  |
|--|--|---|--|---|--|---|---|--|--|--|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |   |  |  |  |                               |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |  |  |                               |  |
| 1. DECEASED NAME<br>(Type or print) <del>xxxx</del> Last <i>WARNER;</i> Middle <i>V.</i> <del>xxx</del> First <i>Esther</i>  |  |   |  |   |  | 2a. DATE OF DEATH<br>Month <i>12</i> Day <i>26</i> Year <i>1968</i>   |   |  | 2b. HOUR<br><i>3 45</i> A M  |  |                               |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>white</i>                       |  | 5. DATE OF BIRTH<br><i>8/15/1917</i>  |  |   | 6. AGE (In years last birthday)<br><i>51</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Wash., D.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Montgomery County</i> Md.  |   |  |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Holy Cross Hospital</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Clerk</i>                       |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. Gov't.</i>                        |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MD.</i>  |  |   | 13b. COUNTY<br><i>Montgomery</i>   |   | 13c. CITY OR TOWN<br><i>Sil. Spr.</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>735 Shigo Avenue</i>                              |  |                               |  |
| 14. FATHER'S NAME First <i>Louis</i> Middle <i>--</i> Last <i>Oriani</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME First <i>Maria</i> Middle <i>--</i> Last <i>Cuneo</i>  |  |   |   |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>--</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>578-36-8813</i>   |   | 17. INFORMANT Address <i>Wash., D.C.</i><br><i>Victoria Hiser 1315 Missouri Avenue, N.W.</i> |   |   |  |  |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i><br><i>1621</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>few months</i> |  |   |  |   |  |   |   |  |  |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>162X</i>   |  |   |  |   |  |   |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)<br>OFFICE BUILDING, ETC                              |   |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |   |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/2, 1968</i> to <i>12/25, 1968</i> ; that (I) <del>(was)</del> lost<br>saw the deceased alive on <i>12/25, 1968</i> ; and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(was)</del> <del>(did)</del> <del>(did not)</del> view the body after death.                           |  |   |  |   |  |   |   |  |  |  |                               |  |
| 22b. SIGNATURE<br><i>G. Lennard Gold</i> DEGREE  |  |   |  |   |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><i>12/26/68</i>  |  |                               |  |
| 22d. PHYSICIAN'S NAME (Type) <i>G. Lennard Gold, M.D.</i>  |  |   |  |   |  | 22e. ADDRESS<br><i>9801 Georgia Avenue, Sil. Spr., Md.</i>  |   |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>12-30-1968</i>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Suitland Pr. Geos. Md.</i> |  |                               |  |
| 24. FUNERAL DIRECTOR<br><i>W. Lee Jeter</i><br><i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>   |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br><i>IAN 3</i> 1969  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                             |  |                               |  |

MEDICAL CERTIFICATION



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VR 415  
30M REV. 7-68

17996

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17997

# CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Martha U. WARREN</u>  |  |  | 2a. DATE OF DEATH<br>Month <u>December</u> Day <u>1</u> Year <u>1968</u> |   |  | 2b. HOUR<br><u>6:15 AM</u>   |  |
| 3 SEX<br><u>Female</u>   |  | 4. RACE<br><u>CAUC.</u>  |  | 5. DATE OF BIRTH<br><u>Sept. 21 1880</u>  |  | 6. AGE (n years last birthday)<br><u>87</u> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Montgomery</u>  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Bethesda</u>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>GROSVENER LANE NURSING HOME</u> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>   |  |
| 13a. US JAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE<br><u>md.</u>   |  | 13b. COUNTY<br><u>Montgomery</u>   |  | 13c. CITY OR TOWN<br><u>Silver Spring</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><u>9302 North Ave.</u>   |  | 14. FATHER'S NAME First <u>JAMES</u> Middle <u>J.</u> Last <u>CRABTREE</u>   |  | 15. MOTHER'S MAIDEN NAME First <u>Hannah</u> Middle <u>J.</u> Last <u>Moore</u>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) <u>No</u>   |  | 16b. SOCIAL SECURITY NO. <u>227-05-5311</u>  |  | 17. INFORMANT Address<br><u>John E. Hawk 808 Hobbs Drive, Sil. Spr., Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u>   |  |  |  |   |  |  | <u>instant</u>                               |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u>   |  |  |  |   |  |  | <u>years</u>                                 |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>4221</u>   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Sensitivity severe cellulitis &amp; decubiti moderate</u>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>Dec. 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 30</u> , 19 <u>68</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Wilfred R. Ehrmantrout MD</u>   |  | DEGREE   |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                               |  | 22c. DATE SIGNED<br><u>12/1/68</u>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Wilfred R. Ehrmantrout</u>  |  | 22e. ADDRESS<br><u>11125 Rockville Pike Rockville Md</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>12-3-1968</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Colesville Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Montgomery Maryland</u>                  |  |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey, Inc.</u>  |  | ADDRESS<br><u>Sil. Spr. Md.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>REC</u> 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17998

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| 1 DECEASED-NAME<br>(Type or print) First Middle Last<br>Sadie Elizabeth Warren  |   |  | 2a DATE OF DEATH<br>Month Day Year<br>Dec 30 1968  |  | 2b. HOUR<br>12.02 M   |
| 3. SEX<br>Female  | 4. RACE<br>Negro  | 5. DATE OF BIRTH<br>6/29/1877  |  | 6. AGE (In years<br>last birthday)<br>91 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a BIRTHPLACE (State or foreign<br>country)<br>Md.  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Montgomery Md  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Wheaton  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>University Nursing Home | 12a USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>house wife   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before<br>admission) STATE<br>DC.   | 13b COUNTY<br>V   | 13c CITY OR TOWN<br>Washington   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER<br>4624 New Hampshire Avenue                                   |   |
| 14. FATHER'S NAME First Middle Last   |   | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CEREBRAL ARTERY THROMBOSIS<br>4. DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH GAVE<br>RISE TO IMMEDIATE CAUSE (a),<br>STATING THE UNDERLYING CAUSE<br>LAST. (b) GENERALIZED ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>332x  |   |  |  |  |   |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |   |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |  | 21f LOCATION Street or R.F.D. No City or Town County State                           |   |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 12/29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |  |   |
| 22b SIGNATURE<br>Pedro I. Matias  |   |  |  | 22c. DATE SIGNED<br>12/30/68   |   |
| 22d. PHYSICIAN'S<br>NAME (Type) PEDRO I. MATIAS, M.D.   |   | 22e ADDRESS<br>4712 Montgomery PL Bethesda Md  |  |  |   |
| 23a BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |   | 23b DATE<br>1-4-69   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Church cemetery                                 |   |
| 24. FUNERAL DIRECTOR<br>John D. Watson  |   | ADDRESS<br>3435-14-St. John  |  | 23d. LOCAT ON (City or Town) (County) (State)<br>Montgomery County Md                |   |
| 25a REC'D BY REGISTRAR<br>DATE DEC 31 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |        |   |   |   |  |   |  |   |  |
|---|--------|---|---|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |        |   |   |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(Type or print)  |        |   | First   | Middle  | Last                                       | 2a. DATE OF DEATH<br>Month Day Year   |  |   | 2b. HOUR                                     |
| CHARLES L. Washington   |        |   |   |   |  | Dec. 29 1968  |  |   | 11:29 AM                                     |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH   |   | 6 AGE (In years last birthday)  |  | 7 UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |
| MALE  | NEGRO  | 7/06/09   |   | 59 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.  |  |
| 7a BIRTHPLACE (State or foreign country)  |        | 7b CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH   |  |   |  |
| Montgomery  |        | USA   |   |   |  | Montgomery  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |        |   | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) |   |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Montgomery  |        |   | Suburban  |   |  | Laborer   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |        |   | 13b. COUNTY   |   | 13c CITY OR TOWN                           |   | 13d INS. DE CITY L.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET AND NUMBER                        |
| MD  |        |   | Montgomery (German town)  |   |  |   |  |   | Rt 118                                       |
| 14 FATHER'S NAME  |        |   | First   | Middle  | Last                                       | 15. MOTHER'S MAIDEN NAME  |  |   | First Middle Last                            |
| HEZIKAH Washington  |        |   |   |   |  | Lila Fairfax  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown  |        |   | 16b. SOC. SEC. NO.  |   | 17 INFORMANT                               |   |  |   | Address                                      |
| No  |        |   | 518-22-7404   |   | Gladys Washington, Wife, German town       |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) Coronary Occlusion 1964<br>(c) Arteriosclerotic C-V Dis. 1962 |        |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>No   |        |   |   |   |  |   |  |   |  |
| 19a DATE OF OPERATION   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |        |   |   |   |  |   |  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |        | 21b TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
|   |        |   |   |   |  |   |  |   |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |        | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
|   |        |   |   |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 1962 to 12-29, 1968, that (I) (we) saw the deceased alive on Nov. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |        |   |   |   |  |   |  |   |  |
| 22b SIGNATURE<br>Clive E. Jackson, M.D.   |        |   |   |   | 22c DATE SIGNED<br>12-30-68                |   | 22d PHYSICIAN'S NAME (Type)<br>22e ADDRESS<br>202 Martin Ln., Rockville, Md.       |   |  |
|   |        |   |   |   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |        | 23b DATE  |   | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION (City or Town) (County) (State)  |  |   |  |
| BURIAL  |        | 1-2-1969  |   | Brooke Grove Cem  |  | Laytonsville, Montgo. Md.   |  |   |  |
| 24 FUNERAL DIRECTOR<br>Robert L. Swartzel, Rockville, Md.   |        |   |   |   | 25a REC'D BY REG. STRAR<br>DATE JAN 3 1969 |   | 25b REGISTRAR'S SIGNATURE<br>Charles Judge   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

18000

|  |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|--|--|---|--|--|
| 1 DECEASED-NAME<br>(Type or print) <b>MARIE</b>  |  |  | First Middle Last <b>A. WATERS</b>   |  |  | 2a. DATE OF DEATH<br><b>DEC</b> Month <b>14</b> Day <b>68</b> Year   |  |  | 2b HOUR<br><b>1145P</b> M   |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>NEGROID</b>  |  |  | 5. DATE OF BIRTH<br><b>17 DEC 1915</b>   |  |  | 6 AGE (In years last birthday)<br><b>52</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VA</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>NAVAL HOSPITAL</b> |  |  | 12a USAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>  |  |  |
| 13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><b>D.C.</b>  |  |  | 13b COUNTY<br><b>WASHINGTON</b>  |  |  | 13c CITY OR TOWN<br><b>WASHINGTON</b>  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br><b>WILLIAM T. BETTS</b>  |  |  | First Middle Last  |  |  | 15 MOTHER'S MAIDEN NAME<br><b>MARY E. EVANS</b>  |  |  | First Middle Last   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO<br><b>214-22-9767</b>  |  |  | 17 INFORMANT<br><b>MR. HERBERT WATERS, 1320 MISS. AVE., S.E.</b>   |  |  | Address   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF LEFT BREAST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>1/16</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  | 21f. LOCATION Street or R.F.D. No City or Town County State  |  |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11 DEC 68, 19 68</b> to <b>14 DEC 19 68</b> , that (we) last saw the deceased alive on <b>14 DEC 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                            |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Donald Roeder</b>   |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><b>15 DEC 68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DONALD ROEDER, MD. (LCDR MC USN)</b>  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, BETHESDA, MARYLAND</b>                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12-19-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                      |  |  |
| 24. FUNERAL DIRECTOR<br><b>Randolph Collick, 2431 E. Oliver St., Balt., Md.</b>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 18 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |  |  |

VR A15 (4)  
45M 1/69



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                      |   |  |  |  |  |   |  | 18001   |  |
|--|--|----------------------|---|--|--|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |   |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or Print) <u>DEWEY</u>   |  |                      | First Middle Last <u>WATKINS</u>  |  |  | 2a. DATE KNOWN OF DEATH: ESTIMATED <input checked="" type="checkbox"/> 12 12 1968  |  |   | 2b. HOUR <u>9:30</u> M   |   |  |
| 3. SEX <u>male</u>   |  | 4. RACE <u>white</u> |   | 5. DATE OF BIRTH <u>Jan 28-1904</u>  |  | 6. AGE (In years last birthday) <u>70</u> YRS.   |  | 7. UNDER 1 YEAR: MONTHS <u>0</u> DAYS <u>0</u>  |  | 8. IF UNDER 24 HRS: HOURS <u>0</u> MIN <u>0</u> |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Montg &amp; Md</u>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH <u>Montgomery</u> Md  |   |  |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u>  |  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban Hospital</u> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired</u>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <u>Md</u>   |  |                      | 13b. COUNTY <u>Montgomery</u>   |  |  | 13c. CITY OR TOWN <u>Gaithersburg</u>  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13e. STREET AND NUMBER <u>18529 Strawberry Rd.</u>   |  |                      | 14. FATHER'S NAME: First <u>Edridge</u> Middle <u>Watkins</u> Last <u></u>                            |  |  | 15. MOTHER'S MAIDEN NAME: First <u>Emma</u> Middle <u>Barton</u> Last <u></u>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                      | 16b. SOCIAL SECURITY NO   |  |  | 17. INFORMANT <u>Willie Watkins</u>  |  |   | ADDRESS <u>Not in city sub</u>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke inhalation and burns, diffuse, 40%</u><br><u>10A</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>                         |  |                      |   |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                      |   |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |   | 21b. TIME OF INJURY Month Day Year <u>9:30 P.M. Dec-12-1968</u>                          |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Trapped in house fire</u>                             |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                      |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u> |  |  |  | 21f. LOCATION Street or R.F.D. No <u>18529 Strawberry Knoll Rd</u> City or Town <u>Gaithersburg</u> County <u>Mont.</u> State <u>MD</u> |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |   |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D.  |  |                      |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <u>Dec. 13, 1968</u>   |  |   |  |
| EXAMINER'S NAME (Type) <u>John G. Ball</u>   |  |                      |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                              |  |  |  | ADDRESS (Street, city, town, or county) <u></u>   |  |   |  |
| 23a. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>   |  |                      | 23b. DATE <u>12-16-68</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>   |  |   | 23d. LOCATION (City or Town) <u>Gaithersburg</u> (County) <u>Montg</u> (State) <u>Md</u>     |   |  |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>  |  |                      |   | ADDRESS <u>Gaithersburg, Md</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>DEC 19 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |   |                                    |   |  |                                   |   |  |  |
|--|--|------------------------------|--|---|------------------------------------|---|--|-----------------------------------|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |                                    |   |  |                                   |   |  |  |
| 17001  |  |                              |  |   |                                    |   |  |                                   |   |  |  |
| 18002  |  |                              |  |   |                                    |   |  |                                   |   |  |  |
| CERTIFICATE OF DEATH   |  |                              |  |   |                                    |   |  |                                   |   |  |  |
| 1 DECEASED NAME<br>(Type or print)   |  |                              | First Middle Last  |   |                                    | 2a. DATE OF DEATH   |  | 2b. HOUR                          |   |  |  |
| Catherine  |  |                              | Irene Watts  |   |                                    | Month 12 Day 20 Year 68   |  | 11:30 AM                          |   |  |  |
| 3. SEX   |  | 4 RACE                       |  | 5. DATE OF BIRTH  |                                    | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR                   |   |  |  |
| Female   |  | Negro                        |  | 6/22/1887   |                                    | 81 YRS.   |  | MONTHS DAYS HOURS MIN             |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  | Md.                               |   |  |  |
| Virginia   |  | USA                          |  |   |                                    | Montgomery  |  |                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |
| Wheaton,   |  |                              | University Nurs. Home  |   |                                    | Domestic  |  |                                   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE   |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER  |  |  |
| Wash., DC  |  |                              | 1  |   | Wash., DC                          |   | YES  |                                   | 24 Bryant St., NW   |  |  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME   |   |                                    |   |  |                                   |   |  |  |
| First Middle Last  |  |                              | First Middle Last  |   |                                    |   |  |                                   |   |  |  |
| William Osborne  |  |                              | Cornelia Barner  |   |                                    |   |  |                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT Address   |  |                                   |   |  |  |
| no   |  |                              | 577-24-2413  |   |                                    |   |  |                                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                              |  |   |                                    |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4120   |  |                              |  |   |                                    |   |  |                                   | 1 month   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) 4120  |  |                              |  |   |                                    |   |  |                                   | 5 yrs   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) 4120  |  |                              |  |   |                                    |   |  |                                   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |   |                                    |   |  |                                   |   |  |  |
| 19a. DATE OF OPERATION   |  |                              |  |   |                                    |   |  |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              |  |   |                                    |   |  |                                   | 21b. TIME OF INJURY HOUR A.M. Month Day Year 1968                           |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>   |  |                              |  |   |                                    |   |  |                                   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. |  | 21f. LOCATION Street or R.F.D. No City or Town County State                    |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/68, to 11/20/68, that (I) (we) last saw the deceased alive on 11/20/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death |  |                              |  |   |                                    |   |  |                                   | 22b. SIGNATURE Edward Mazique, MD   |  | 22c. DATE SIGNED 12/20/68  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |   |                                    |   |  |                                   | 22e. ADDRESS  |  |  |
| Edward Mazique, MD   |  |                              |  |   |                                    |   |  |                                   | 1801 9th St., NW, Wash., DC   |  |  |
| 23a. (BURIAL) CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)  |                                   |   |  |  |
| 12-24-68   |  |                              | 12-24-68   |   | Sincere Mem.                       |   | Sincere Mem.   |                                   |   |  |  |
| 24. FUNERAL DIRECTOR   |  |                              | ADDRESS  |   | 25a. REC'D BY REGISTRAR            |   | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |  |
| Hoyan Funeral Home R. San  |  |                              | 587  |   | DEC 27 1968                        |   | J. Charles Judge   |                                   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |   |   |  |                                   |  |
|--|--|---|--|--|---|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |   |   |  |                                   |  |
| 17002  |  |   |  |  | 18003   |   |  |                                   |  |
| 1. DECEASED NAME (Type or print)   |  |   |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR                          |  |
| First Middle Last<br>ANNETTE WEINER  |  |   |  |  | Month Day Year<br>12 4 68   |   |  | 22 p M                            |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |
| FEMALE   |  | WHITE   |  | 6-5-15   |   | 53 YRS.   |  | MONTHS DAYS HOURS MIN             |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                   |  |
| MD   |  | USA   |  |  |   | Montgomery County Md  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Silver Spring, Md  |  |   | Holy Cross   |  |   | HOUSEWIFE   |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| MD   |  |   | Montgomery   |  | Silver Spring   |   | YES  |                                   | 714 Lowander Lane                            |
| 14. FATHER'S NAME First Middle Last  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |  |                                   |  |
| SAMUEL HINDIN  |  |   | KAY MERICAN  |  |   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT Address   |   |  |                                   |  |
| NO   |  |   | 213-103928   |  | Helen Weiner Same As 13   |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))  |  |   |  |  |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |   |   |  |                                   |  |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE  |  |   |  |  |   |   |  |                                   | 2 YRS.                                       |
| 4339 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL THROMBOSIS  |  |   |  |  |   |   |  |                                   | 3 DAYS                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS   |  |   |  |  |   |   |  |                                   | 1-2 YRS.                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |   |   |  |                                   |  |
| 332X NONE  |  |   |  |  |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |
| NONE   |  |   |  |  |   |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                   |  |
|  |  |   |  |  |   |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |                                   |  |
|  |  |   |  |  |   |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/68, to 12/4/68, that (I) (we) last saw the deceased alive on 12/4/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |                                   |  |
| 22b. SIGNATURE Harold Stein  |  |   |  |  | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED 12/4/68   |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) HAROLD STEIN, MD  |  |   |  |  | 22e. ADDRESS 1352 UNIV BLVD EAD   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |
| BURIAL   |  | 12-6-1968   |  | BETH BAR ADATH HASIDIC BALTIMORE   |   | BALTIMORE STATE MD  |  |                                   |  |
| 24. FUNERAL DIRECTOR Medley Funeral Home 4217 GARDEN AVE   |  |   |  |  | 25a. REC'D BY REGISTRAR DATE DEC 5 1968   |   | 25b. REGISTRAR'S SIGNATURE [Signature]   |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

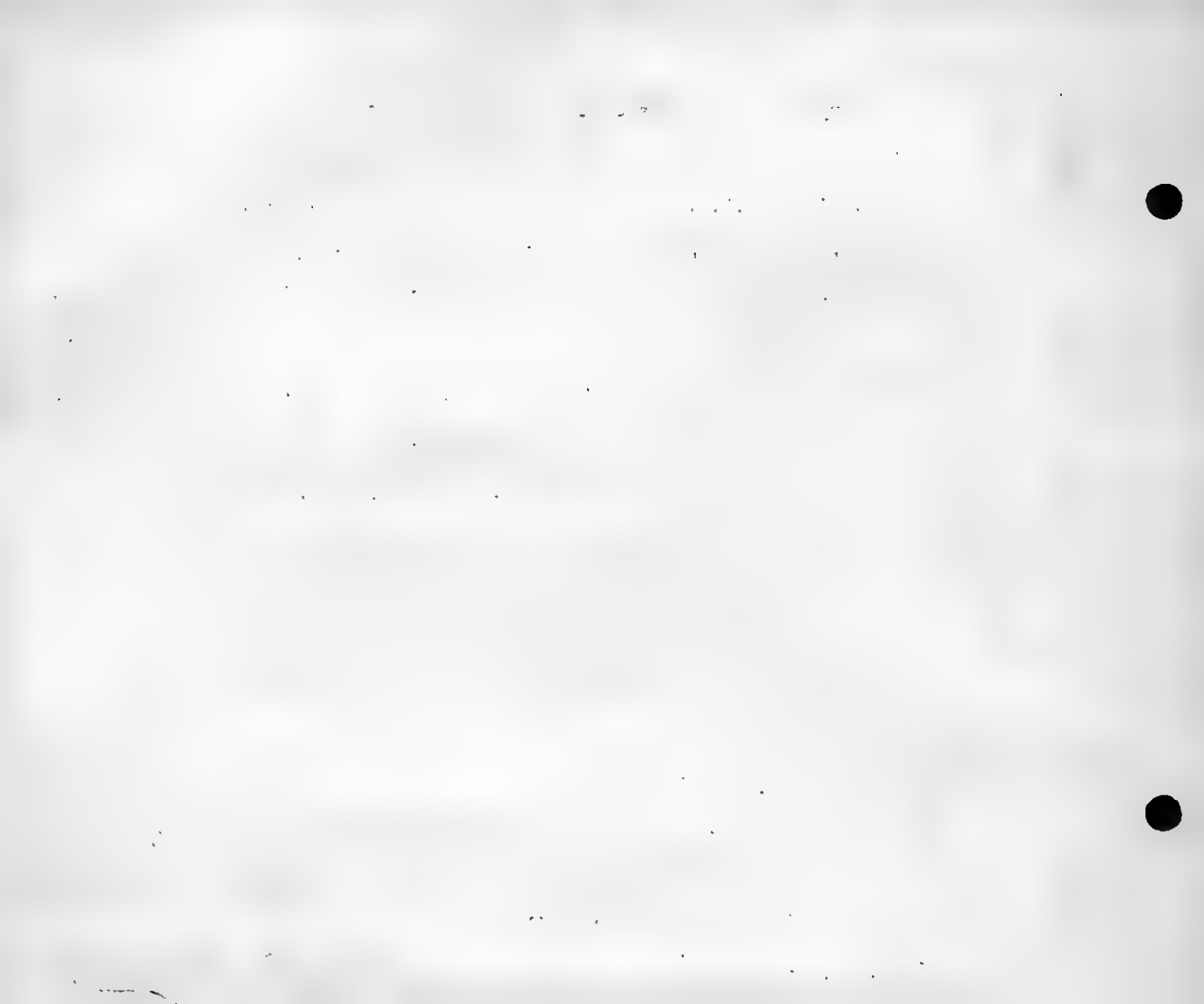
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 3, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |   |   |  |   |              |
|---|--|---|--|--|---|---|--|---|--------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |   |  |   |              |
| CERTIFICATE OF DEATH  |  |   |  |  |   |   |  |   |              |
| 1 DECEASED-NAME<br>(Type or print) <b>BERTHA COLLIER WEINSTEIN</b>  |  |   |  |  | 2a. DATE OF DEATH<br>Month <b>12</b> Day <b>5</b> Year <b>68</b>  |   |  | 2b. HOUR<br><b>7:45 PM</b>                                    |              |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br><b>6-11-96</b>  |   | 6 AGE (In years last birthday)<br><b>72</b> YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                      |              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Mass.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.                                       |  |   |              |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park,</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. San. &amp; Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on adm ssion) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |   | 13d. INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8250 New Hampshire Ave.</b>      |              |
| 14. FATHER'S NAME<br>First <b>Isador Aaronson</b> Middle <b></b> Last <b></b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Flora Breitstein</b> Middle <b></b> Last <b></b>  |   |   |  |   |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>None</b>  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT<br><b>Mrs. Sylvia Davis, as above</b> Address <b>Dtr.</b>  |   |   |  |   |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 HRS.</b> |              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>422</b>  |  |   |  |  |   |   |  |   |              |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |   |  |   |              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |  |  | 21f. LOCATION Street or R.F.D. No   |   | City or Town   |   | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>68</b> , to <b>12-5</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |   |  |   |              |
| 22b. SIGNATURE<br><b>Myron L. Lendon, MD</b>  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12-5-68</b>                                   |   |              |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  |  | 22e. ADDRESS  |   |  |   |              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/8/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyattsville, Md.</b>          |  |   |              |
| 24. FUNERAL DIRECTOR<br><b>Bernard Danzansky &amp; Sons</b>   |  |   |  | ADDRESS<br><b>3501 14th St Wash., D.C.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 11 1968</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>            |              |



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  |
| 17901 CERTIFICATE OF DEATH 18665  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |
| Mary  |  |  | Claudine Wells   |  |  | Dec 22 Month Day Year 68   |  |  | M  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (in years lost birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN  |  |
| F   |  | W  |  | April 6, 1876  |  | 92 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Pennsylvania  |  | U.S.A.   |  |  |  | Montgomery Md  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Gaithersburg  |  |  | Asbury Methodist Home  |  |  | Housewife  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Virginia  |  |  |  |  |  | Arlington  |  | 4201-13th Street, South  |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |
| Samuel Byerly   |  |  | Mary Ann Byerly  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT Address  |  |  |  |  |
| no  |  |  | 218-54-9127  |  | Asbury Methodist Home, Gaithersburg, Md.                               |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Atherosclerosis</u> (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>20 YRS.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4109</u>  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No City or Town County State  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/18/64</u> 19 <u>64</u> to <u>12/22/68</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/22/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Henry C. Scruggs</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED <u>12/22/68</u>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs   |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 12-27-68   |  | Tioga Point  |  | Athens, Penn   |  | Pa   |  |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS <u>Gaithersburg, Md.</u>  |  |  |  | 25a. REC'D BY REGISTRAR DATE <u>DEC 27 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                      |  |  |  |





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17895

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18006

# CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print)<br>First Middle Last<br><b>ATala IRENE Wendell</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>12 19 68</b> |   |  | 2b. HOUR<br>MIN<br><b>11P</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br><b>Feb. 18, 1888</b>   |  | 6 AGE (In years last birthday)<br><b>80</b> YRS                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Cann</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><b>Montgomery</b> Md  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Potomac Valley Nursing Home</b> |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>R.N.</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a SOCIAL RESIDENCE (Where deceased lived, if institution admission) STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>AR</b>   |  | 13c CITY OR TOWN<br><b>WASH D.C.</b>  |  | 13d. HOUSE CITY, DIST?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>First Middle Last<br><b>JOHN PETTER WHALEY</b>   |  | 15 MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>MARY BURRAWS</b>  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br><b>04-208 643 280424</b>                      |  | 17 INFORMANT<br><b>(SON) WM. D. WENDEL JR.</b>  |  | Address<br><b>3501 ARGYLE ST. NW WASH D.C.</b>                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>609X</b><br>(b) <b>Urinary Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>?</b> |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ASHD, EVA Gen. ulcers</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR AM Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |  |  |  |
| 21a. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)<br>OFFICE BUILDING, ETC                                      |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>19 Dec</b> , 19 <b>68</b> , to <b>19 Dec</b> , 19 <b>68</b> , that (i) (we) last saw the deceased alive on <b>19 Dec</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.   |  |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>John S. Soia MD</b> DEGREE<br>ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| 22d PHYSICIAN'S NAME (Type)  |  | 22e ADDRESS<br><b>609 Vicksburg Rd.</b>  |  |   |  |  |  |
| 23a BURIAL, CREMATION REMOVAL (Specify)<br><b>cremation</b>  |  | 23b DATE<br><b>12-21-68</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |  | 23d LOCATION (City or Town) (County) (State)<br><b>Coleman Manor Md</b>            |  |
| 24 FUNERAL DIRECTOR<br><b>W. W. Chamber C</b>  |  | ADDRESS<br><b>1400 Bayview St N.W. Wash D.C.</b>   |  | 25a RECD BY REGISTRAR<br>DATE<br><b>DEC 31 1968</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                  |  |



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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |   |  |
| 18007   |  |   |  |   |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or print) <b>MARY CATHERINE WERLE</b>   |  |   | First Middle Last  |   |  | 2a. DATE OF DEATH<br><b>12</b> Month <b>28</b> Day <b>68</b> Year  |   |  | 2b. HOUR<br><b>6:35</b> PM                                      |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUC.</b>   |  | 5. DATE OF BIRTH<br><b>JAN. 7. 1879</b>   |  |  | 6. AGE (In years last birthday)<br><b>89</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>WASH. D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |   |  | Md  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FAIRLAND</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>FAIRLAND NURSING HOME</b> |   |  | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm.) STATE<br><b>WASH. D.C.</b>  |  |   | 13b. COUNTY<br><b>WASH. D.C.</b>   |   |  | 13c. CITY OR TOWN<br><b>WASH. D.C.</b>   |   | 13d. INSIDE CITY (Y/N) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1635 WEBSTER ST. N.E.</b> |
| 14. FATHER'S NAME<br><b>AUGUST NEFF</b>   |  |   | First Middle Last  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>WILKINSON</b>   |   |  | First Middle Last<br><b>Julia Brooke</b>                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO<br><b>216-16-4372</b>  |   |  | 17. INFORMANT<br><b>FROM MEDICAL RECORD</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Generalized cerebral arteriosclerosis<br>(b) <b>Generalized debilitation</b><br>(c) <b>Chronic hypochromic anemia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Chronic hypochromic anemia</b> |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 days</b> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR AM Month Day Year<br>PM 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY)<br>OFFICE BUILDING, ETC |  | 21f. LOCATION Street or R.F.D. No   |  | City or Town   |   | County State   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-15</b> , 1963, to <b>12-28</b> , 1968, that (I) (we) lost saw the deceased alive on <b>12-28</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John R. Spencer, MD</b>  |  |   |  | DEGREE  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12-28-68</b>  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John R. Spencer</b>  |  |   |  | 22e. ADDRESS<br><b>BURTONSVILLE, MD</b>   |  |  |   |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-31-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   |  | 23d. LOCATION (City or Town)   |   | (County) (State)<br><b>Washington, D. C.</b>   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Francis J. Callers</b>   |  |   |  | ADDRESS<br><b>500 University Blvd<br/>Silver Spring, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 3 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |  |



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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  |
| 1 DECEASED NAME<br>(Type or print) <b>MARGARET</b>  |  |  | First <b>R.</b> Middle <b>W.</b> Last <b>Whitcomb</b>   |  |  | 2a DATE OF DEATH<br>Month <b>12</b> Day <b>14</b> Year <b>1968</b>  |  |  | 2b HOUR<br><b>10:40</b> AM  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  |  | 4 RACE<br><b>WHITE</b>  |  |  | 5 DATE OF BIRTH<br><b>1-25-1876</b>   |  |  | 6 AGE (In years last birthday)<br><b>92</b> YRS   |  |  |
| 7a BIRTHPLACE (State or foreign country)<br><b>Wash. D.C.</b>   |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>KENSINGTON</b>   |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)<br><b>NURSING HOME KENSINGTON GARDENS</b> |  |  | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)<br><b>Housewife</b>  |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE<br><b>Md</b>   |  |  | 13b COUNTY<br><b>MONTGOMERY</b>   |  |  | 13c CITY OR TOWN<br><b>TAPOMA</b>   |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br><b>BENJAMIN</b> First <b>Ellin</b> Middle <b>Ellin</b> Last   |  |  | 15 MOTHER'S MAIDEN NAME<br><b>FLORENCE</b> First <b>Riggles</b> Middle <b>Riggles</b> Last                            |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>220-46-9441</b>   |  |  |
| 17 INFORMANT<br><b>Edwin Whitcomb</b>   |  |  | Address<br><b>8409 Ridgely Ave. D.C.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>advanced arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 1/2 yrs.</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b>                               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>420 Cerebral vascular accident with rt. hemiplegia 11/12/68</b>   |  |  |   |  |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)   |  |  |   |  |  |
| 21d INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)  |  |  | 21f LOCATION Street or R.F.D. No City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1966</b> to <b>Dec 14, 1968</b> ; that (I) (we) last saw the deceased alive on <b>Dec 9, 1968</b> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |
| 22b SIGNATURE<br><b>D.B. Washington M.D.</b>  |  |  | DEGREE  |  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>  |  |  | 22c DATE SIGNED<br><b>12/14/68</b>  |  |  |
| 22d PHYSICIAN'S NAME (Type)<br><b>D.B. Washington M.D.</b>  |  |  | 22e ADDRESS<br><b>5802 Ridgely Rd Bethesda Md 20816</b>   |  |  |   |  |  |   |  |  |
| 23a BURIAL (CREMATION, REMOVAL) (Specify)<br><b>Burial</b>  |  |  | 23b DATE<br><b>12-16-68</b>   |  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   |  |  | 23d LOCATION (City or Town) (County) (State)<br><b>Washington D.C.</b>                      |  |  |
| 24 FUNERAL DIRECTOR<br><b>M. Andrew Duwall</b>  |  |  | ADDRESS<br><b>Warner E. Pumphrey Inc. 8434 1/2 Ave. S.S., Md</b>  |  |  | 25a REC'D BY REGISTRAR<br><b>DEC 19 1968</b>  |  |  | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18009

|  |                     |   |   |   |                             |  |  |  |
|--|---------------------|---|---|---|-----------------------------|--|--|--|
| 1. DECEASED-NAME (Type or Print) <u>Care</u> First <u>Estlin</u> Middle <u>White</u> Last  |                     |   |   |   |                             | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 12/17 1968 2b. HOUR 3:30 P.M. |  |  |
| 3 SEX <u>Male</u>  | 4 RACE <u>White</u> | 5 DATE OF BIRTH <u>5/22/17</u>  | 6 AGE (in years past birthday) <u>51</u> YRS                                  | 7 UNDER YEAR MONTHS   | 8 IF UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month <u>12</u> Day <u>7</u> Year <u>1968</u>                               |  | 2d. HOUR 3:33 P.M.   |
| 7a. BIRTHPLACE (State or foreign country) <u>Wash DC</u>   |                     | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>         |                             | 9. COUNTY OF DEATH <u>Montgomery</u> Md.   |  |  |
| 10 CITY OR TOWN OF DEATH <u>Bethesda</u>   |                     | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <u>DC</u>   |                     | 13b. COUNTY <u>Washington</u>   |   | 13c. CITY OR TOWN <u>Washington</u>   |                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | 13e. STREET AND NUMBER <u>1745 Upshaw St NW</u>                                |
| 14. FATHER'S NAME First <u>Leroy</u> Middle <u>T</u> Last <u>White</u>   |                     |   | 15. MOTHER'S MAIDEN NAME First <u>Anne</u> Middle <u>E</u> Last <u>Estlin</u> |   |                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>  |                     | 16b. SOCIAL SECURITY NO (If yes give war or dates of service)                               |   | 17 INFORMANT <u>Mrs Anne Estlin</u>   |                             | ADDRESS <u>Rock Beach Md</u>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction Acute.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Thrombosis Coronary Artery</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                     |   |   |   |                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Recent</u><br><u>Recent</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>42c</u>   |                     |   |   |   |                             |  |  |  |
| 19a. DATE OF OPERATION   |                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |   |                             | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <u>19</u>                            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                             |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                             |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                     |   |   |   |                             |  |  |  |
| ACTUAL SIGNATURE <u>John B. Ball</u>   |                     | EXAMINER'S NAME (Type)  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                             | 22b. DATE SIGNED <u>Dec. 8, 1968.</u>  |  |  |
| 23a. B. RIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  |                     | 23b. DATE <u>12/10/68</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>   |                             | 23d. LOCATION (City or Town) (County) (State) <u>Friendship Md</u>                                   |  |  |
| 24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u>  |                     |   |   | ADDRESS <u>Owings, Md</u>   |                             | 25a. REC'D BY REGISTRAR DATE <u>DEC 13 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17000

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18010

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br><b>MARCUS ALVIN WHITE</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 21 1968</b> |   |  | 2b. HOUR<br>9 45 P. M.   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>2/24/34</b>  |  | 6. AGE (In years last birthday)<br><b>34</b> YRS   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING MD.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Draft Engineer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>HOWARD</b>   |  | 13c. CITY OR TOWN<br><b>WOODBINE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>RFD #2</b>  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Malvin Maxwell White</b>                                      |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mamie Lillian Hale</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577-44-9977</b>   |  | 17. INFORMANT<br>Address<br><b>Hospital Records</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Metastatic Fibrosarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Fibrosarcoma, Right arm</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2 yrs</b><br><b>5 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>1977</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1968   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 1968</b> to <b>12/21 1968</b> , that (I) (we) lost the deceased alive on <b>12/21 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>G. Leonard Gold</b>   |  |  |  | 22c. DATE SIGNED<br><b>12/21/68</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>G. Leonard Gold</b>   |  |  |  | 22e. ADDRESS<br><b>Silver Spring - Md</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT<br><b>Reinterment</b>  |  | 23b. DATE<br><b>Dec. 24 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Glenwood Howard Md.</b>                  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Francis H. Barber Laytensville Md</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 26 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
18000  
18011  
CERTIFICATE OF DEATH

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>                |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5709 LONE OAK DR.</u>   |   | d. STREET ADDRESS <u>5709 LONE OAK DR.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>EDNA TOPHAM WHITTET</u>   |   | 4. DATE OF DEATH <u>12 - 28 - 1968</u>   |   |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 29, 1890</u>                             |
| 9. AGE (in years last birthday) <u>77</u> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>   |   |
| 11. BIRTHPLACE (County & State or foreign country) <u>WASH. D.C.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>GEORGE TOPHAM</u>  |   | 14. MOTHER'S MAIDEN NAME <u>MARGARET REESE SOUTHERLAND</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>  |   | 16. SOCIAL SECURITY NO. <u>214-52-4028</u>   |   |
| 17. INFORMANT <u>DAVID S. WHITTET - ANNANDALE, VA.</u>  |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart disease with myocardial infarction</u><br><u>2509</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u><br>DUE TO (c) <u>Diabetes mellitus</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u><br><u>15+ years</u><br><u>25 years</u> |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2509</u>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                              |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> 19 <u>63</u> to <u>Dec. 28</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>Dec. 21</u> , 19 <u>68</u> , and that death occurred at <u>9:50</u> P.M. from the causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE <u>Richard M. Huffman</u>  |   | 22b. DATE SIGNED <u>12/28/68</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>RICHARD M. HUFFMAN, M.D.</u>  |   | 22d. ADDRESS <u>2001 EYE ST. NW WASH., D.C.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE THEREOF <u>12/31/68</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>  | 23d. LOCATION (City, town or county) (State) <u>SUITLAND, MD.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>JOS. GAWLER'S SONS</u>  |   | 25. REC'D BY REGISTRAR <u>JAN 3 1969</u>   |   |
| ADDRESS <u>5130 WIS. AVE., WASH., D.C.</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |                              |  |  |   |                                 |   |                    |  |  |
|--|--|---|------------------------------|--|--|---|---------------------------------|---|--------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                              |  |  |   |                                 |   |                    |  |  |
| CERTIFICATE OF DEATH   |  |   |                              |  |  |   |                                 |   |                    |  |  |
| 1 DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last            |  |  | 2a. DATE OF DEATH   |                                 |   | 2b. HOUR           |  |  |
| James H. Widner  |  |   |                              |  |  | Month Day Year<br>12 19 1968  |                                 |   | 4 30 PM            |  |  |
| 3 SEX  |  | 4. RACE   |                              | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday) |   |                    | 7. UNDER 1 YEAR                              |  |
| Male   |  | white   |                              | March 13, 1919   |  |   | 49 YRS.                         |   |                    | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |   | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |   | 9. COUNTY OF DEATH |  |  |
| Hawaii   |  |   | U.S.A.                       |  |  |   |                                 |   | Montgomery Md.     |  |  |
| 10. CITY OR TOWN OF DEATH  |  |   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |   |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)      |                    |  |  |
| Silver Spring  |  |   |                              | Holy Cross Hospital  |  |   |                                 | contractor  |                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |  |   |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY - HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    | 13e. STREET AND NUMBER                       |  |
| Maryland   |  |   |                              | Montgomery   |  | Silver Spring   |                                 | YES   |                    | 508 DENNIS AVENUE                            |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME     |  |  |   |                                 |   |                    |  |  |
| First Middle Last  |  |   | First Middle Last            |  |  |   |                                 |   |                    |  |  |
| ELIGA S. WIDNER  |  |   | ROSE SHOWERS                 |  |  |   |                                 |   |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO      |  |  | 17. INFORMANT   |                                 |   | Address            |  |  |
| YES  |  |   | 577-10-0779                  |  |  | Bernice C. Widner   |                                 |   | Same as #13        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |                              |  |  |   |                                 |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |   |                              |  |  |   |                                 |   |                    |  |  |
| IMMEDIATE CAUSE (a) <u>431X</u> <u>cardiac arrhythmia</u>  |  |   |                              |  |  |   |                                 |   |                    | 4 days                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |   |                              |  |  |   |                                 |   |                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |                              |  |  |   |                                 |   |                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |                              |  |  |   |                                 |   |                    |  |  |
|  |  |   |                              |  |  |   |                                 |   |                    |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                              |  |  | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |                    |  |  |
|  |  |   |                              |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                 |   |                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY   |                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |  |   |                                 |   |                    |  |  |
|  |  | HOUR A.M. Month Day Year<br>P.M. 19   |                              |  |  |   |                                 |   |                    |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |                              | 21f. LOCATION  |  | Street or R.F.D. No   |                                 | City or Town  |                    | County State                                 |  |
|  |  |   |                              |  |  |   |                                 |   |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1958, to <u>12-19</u> , 1968, that (I) <del>(we)</del> last saw the deceased alive on <u>12-18</u> , 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death |  |   |                              |  |  |   |                                 |   |                    |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |                              |  |  | 22d. PHYSICIAN'S NAME (Type)  |                                 | 22e. ADDRESS  |                    |  |  |
| <u>Harold T. Kimble, M.D.</u>  |  | 12-19-1968  |                              |  |  | SERUOH T. KIMBLE, M.D.  |                                 | 9801 Georgia Ave, Silver Spring, Md.  |                    |  |  |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify)   |  | 23b. DATE   |                              | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)  |                                 | (County)  |                    | (State)                                      |  |
| <u>Burial</u>  |  | 12-23-68  |                              | Gate of Heaven Cem.  |  | Silver Spring   |                                 | Maryland  |                    |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR   |                              | 25b. REGISTRAR'S SIGNATURE   |  |   |                                 |   |                    |  |  |
| <u>Thomas J. Collins</u>   |  | 500 University Blvd, Silver Spring, Md.                                     |                              | DEC 23 1968  |  | <u>Charles Jones</u>  |                                 |   |                    |  |  |



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

cleared to Medical Examiner 6/15/11 Dr. Reed

## MEDICAL CERTIFICATION

| 18002   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 18013  |  |
|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  |
| FANNIE  |  |  |  | W I E N E R  |  |  |  |
| 2a. DATE OF DEATH   |  | Month  |  | Day  |  | Year   |  |
| 12  |  | 30   |  | 68   |  | 24   |  |
| 2b. HOUR  |  |  |  |  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (in years last birthday)  |  |
| F   |  | Cau  |  | Not Known  |  | 72 YRS   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| Russia  |  | USA  |  |  |  | Montgomery Md  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Wheaton   |  | University of Nursing  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 1200 Bybee St.  |  | Montgomery   |  | Wheaton  |  | 11200 Bybee St.  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| First Middle Last   |  | First Middle Last  |  |  |  |  |  |
| Mavis Brooks  |  | Unknown  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |
| No  |  | No   |  | Milton Wiener  |  | 3578 - Roger Ave. N.Y.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Hypertensive + arteriosclerosis   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |
| Heart Disease   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |
| None  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|   |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
|   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)   |  | 21f. LOCATION Street or R.F.D. No  |  | City or Town County State  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 24, 1966, to Dec 30, 1968, that (I) (we) last saw the deceased alive on Dec 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                            |  | 22c. DATE SIGNED   |  |
| Boris Rabkin MD   |  |  |  |  |  | 12-30-68   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |
| BORIS RABKIN MD   |  | 1019 Univ. Blvd. East  |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |
|   |  | 12/31/68   |  | Mt Ararat Cem.   |  | Pine Lawn - Long Island City   |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Bernard Wanzanow  |  | 3501-14th  |  | DATE JAN 3 1969  |  | Charles Judge  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18003

18014

# CERTIFICATE OF DEATH

|  |  |  |                   |  |   |  |  |   |
|--|--|--|-------------------|--|---|--|--|---|
| 1 DECEASED-NAME<br>(Type or print)   |  | First<br>GENE  | Middle<br>BARBARA | Last<br>WILDER   | 2a DATE OF DEATH<br>Month Day Year<br>DECEMBER 11, 1968 |  |  | 2b HOUR<br>5:40 PM  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>CAUCASIAN  |                   | 5 DATE OF BIRTH<br>JANUARY 3, 1922   |   | 6 AGE (In years<br>146 (In days)<br>YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a BIRTHPLACE (State or foreign<br>country)<br>WEST VIRGINIA   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |                   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 COUNTY OF DEATH<br>MONTGOMERY  |  |   |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA, MARYLAND   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>U. S. NAVAL HOSPITAL                                 |                   | 12a USUAL OCCUPATION (Kind of work done<br>during most of working life, e.g., retired)<br>LINGUIST (NSA)   |   | 12b KIND OF BUSINESS OR<br>INDUSTRY<br>GOVERNMENT  |  |   |
| 13a USUAL RESIDENCE (Where deceased lived,<br>if institution Residence before<br>admission)<br>MARYLAND  |  | 13b COUNTY<br>PRINCE GEORGE'S  |                   | 13c CITY OR TOWN<br>BELTSVILLE   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET AND NUMBER<br>4309 KENNY STREET                      |
| 14 FATHER'S NAME<br>First Middle Last<br>JOSEPH BURDYN   |  | 15 MOTHER'S MAIDEN NAME<br>First Middle Last<br>ROSALEE GORCZYCA   |                   |  |   |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b SOCIAL SECURITY NO<br>236-20-8994  |                   | 17 INFORMANT (HUSBAND) 4309 KENNY STREET<br>STERLING H. WILDER BELTSVILLE, MARYLAND  |   |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MASSIVE INTRACEREBRAL HEMORRHAGE</u><br>4 1.9 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) |  |  |                   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                       |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |                   | 21f. LOCATION Street or R.F.D. No City or Town County State  |   |  |  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 11, 1968, to DECEMBER 11, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 11, 1968, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.                                       |  |  |                   |  |   |  |  |   |
| 22b. SIGNATURE<br><i>John A. Routenberg</i>  |  | DEGREE<br>ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> |                   | 22c. DATE SIGNED<br>DECEMBER 11, 1968  |   |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br>JOHN A. ROUTENBERG, LT MC USN  |  | 22e. ADDRESS<br>U.S. NAVAL HOSPITAL, BETHESDA, MD.   |                   |  |   |  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>12/16/68  |                   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NATIONAL CEMETERY  |   | 23d. LOCATION (City or Town) (County) (State)<br>ARLINGTON, VIRGINIA                           |  |   |
| 24. FUNERAL DIRECTOR<br>NALLEY FUNERAL HOME ADDRESS<br>3200 RHODE ISLAND AVE., MT. RANIER, MD.   |  |  |                   | 25a. REC'D BY REGISTRAR<br>DATE<br>DEC 19 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |
| 18001  |  |  |  |   |   |   |  |  |  |
| 18015  |  |  |  |   |   |   |  |  |  |
| 1 DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR                                     |
| FADELY   |  |  | C. Wiley   |   |   | December 20 1968  |  |  | 12 P M                                       |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | 7. UNDER 1 YEAR                                    |  |
| male   |  | white  |  | Feb. 11 1897  |   | 11 YRS.   |  | MONTHS DAYS HOURS MIN                              |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |  |
| Baltimore Md.  |  | U.S.A.   |  |   |   | Montgomery Md   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Takoma Park  |  |  | Washington San + Hosp.   |   |   |   |  |  | Farmer                                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 13e. STREET AND NUMBER                       |
| Maryland   |  |  | Montgomery   |   | Damascus  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | Bellison Rd.                                 |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |  |  |
| First Middle Last  |  |  | First Middle Last  |   |   |   |  |  |  |
| to Moses Wiley   |  |  | Elizabeth Wiley  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |  |  |
|  |  |  |  |   | Washington San + Hosp Records - Takoma Park   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>coronary occlusion</u><br><u>4104</u> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>lost</u>  |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>T + 11</u>  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>coronary occlusion</u><br><u>atherosclerosis</u> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No   |   | City or Town  |  | County State                                       |  |
|  |  |  |  |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>  </u> , to <u>Dec 20</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>Dec 20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>M. Snow M.D.</u>  |  |  |  |   | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>12. 21-68</u>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   | 22e. ADDRESS<br><u>9013 Flower Ave Silver Spring Md</u>   |   |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>Dec.. 24</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Green Hill Cemetry</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Virginia</u>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Lee Funeral Home</u>  |  |  |  | ADDRESS<br><u>300 4th St. N.E.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 24 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |



18095

## CERTIFICATE OF DEATH

18016

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(Type or print) <i>Mollie</i> First <i>E</i> Middle <i>Wilkins</i> Last  |  |   | 2a. DATE OF DEATH<br>Month <i>Dec</i> Day <i>18</i> Year <i>1968</i>                     |   |  | 2b. HOUR<br><i>11:30</i> M  |  |
| 3 SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br><i>5/18/88</i>  |  | 6. AGE (In years last birthday)<br><i>80</i> YRS.                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>West Va</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Montgomery</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Suburban</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)<br><i>housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE<br><i>Md</i>   |  | 13b. COUNTY<br><i>Mont</i>  |  | 13c. CITY OR TOWN<br><i>Boyd</i>  |  | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME First <i>Aaron</i> Middle <i>Halterman</i> Last   |  |   | 15. MOTHER'S MAIDEN NAME First <i>Shirley</i> Middle <i>Cooper</i> Last <i>Halterman</i> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO<br><i>220-26-49529</i>  |  | 17. INFORMANT<br>Address <i>Artisan Sullivan Halterman Boyd</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>AV dissociation - Cardiac arrest</i>   |  |   |  |   |  |   | <i>70 mins.</i>                              |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i>   |  |   |  |   |  |   | <i>6 days</i>                                |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>atherosclerotic heart disease</i>   |  |   |  |   |  |   | <i>at least 1 year</i>                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>acute cholecystitis complicating above</i>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR <i>A.M.</i> Month <i>Dec</i> Day <i>19</i> Year <i>1968</i>         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 1B)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at home <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  | 21f. LOCATION: Street or RFD No City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12 December 1968</i> to <i>18 December 1968</i> , that (I) (we) last saw the deceased alive on <i>17 December 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Frederick S. Caldwell</i> M.D. DEGREE  |  |   |  | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                                |  | 22c. DATE SIGNED<br><i>12-18-68</i>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>FREDERICK S. CALDWELL</i>  |  |   |  | 22e. ADDRESS<br><i>ROCKVILLE, MD</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><i>12-21-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dormition Presbyterian</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Dormition Montgomery Md</i> |  |
| 24. FUNERAL DIRECTOR<br><i>Ernest G. Gartner</i>  |  | ADDRESS<br><i>1201 E. Gartner</i>   |  | 25a. REC'D BY REGISTRAR<br><i>DEC 23 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>William A. Vande...</i>                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

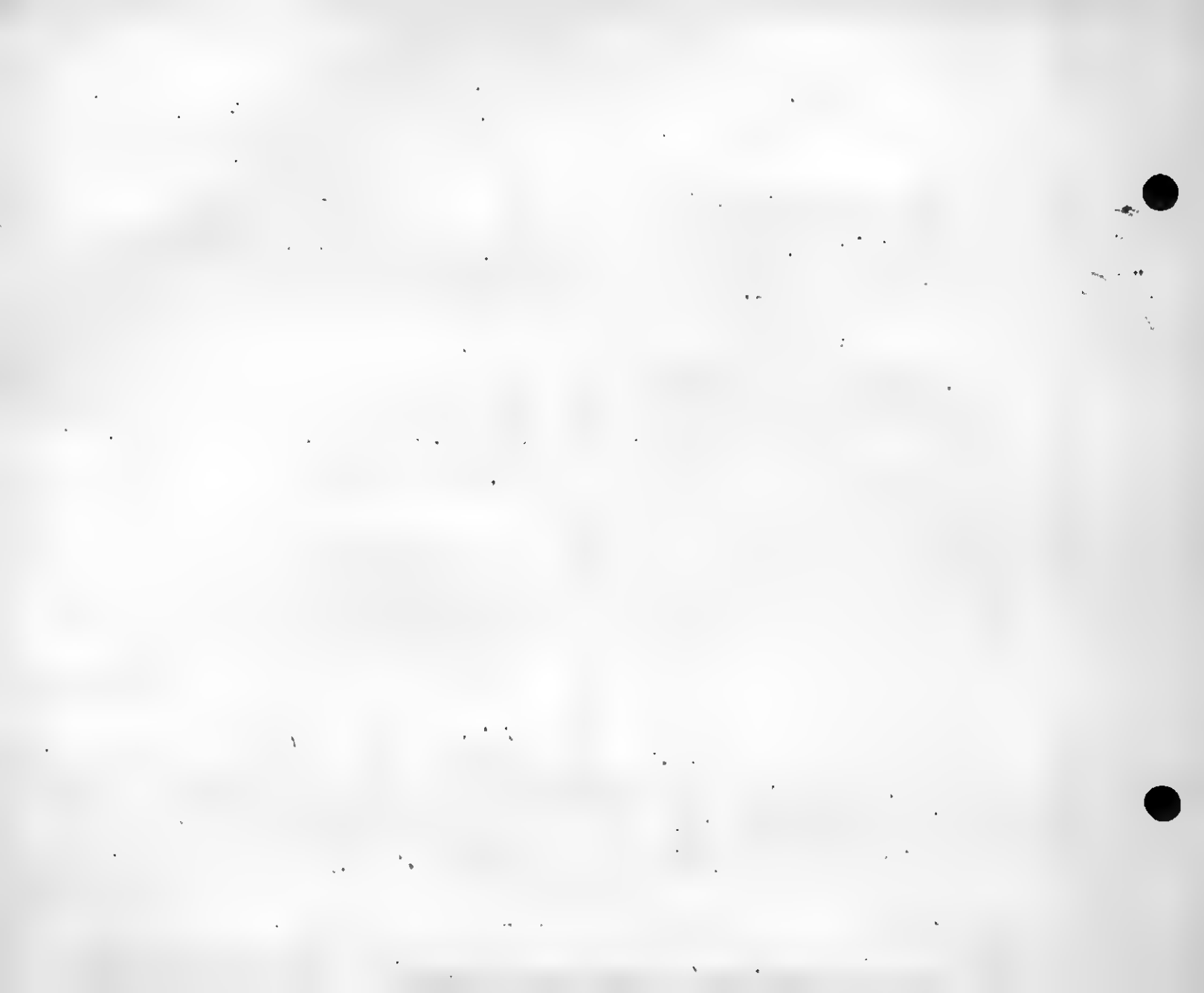


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |                                       |               |  |  |
|--|--|--|--|---|--|---|--|---------------------------------------|---------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |                                       |               |  |  |
| Items#13c&13eFilm#G408 12/31/68 CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                       |               |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Dea First Middle Last</i>   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <i>DEC</i> Day <i>14</i> Year <i>68</i>                              |  |                                       | 2b. HOUR<br>M |  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>Negroid</i>   |  | 5 DATE OF BIRTH<br><i>12-25-1874</i>  |  | 6 AGE (In years last birthday)<br><i>93</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS        |               | IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>MARYLAND</i>   |  | 7b. CITIZEN ON WHAT COUNTRY?<br><i>U.S.A</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><i>Montgomery</i> Md.  |  |                                       |               |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>DARNES TOWN</i>   |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>GREEN Nursing Home</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>HOUSE WIFE</i>                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                       |               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Montgomery</i>   |  | 13c. CITY OR TOWN<br><i>Darnestown</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>none</i> |               |  |  |
| 14. FATHER'S NAME First Middle Last<br><i>Unknown</i>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Unknown</i>                                    |  |                                       |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give year or dates of service)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT Address   |  |   |  |                                       |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular Disease</i><br><i>1120</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Generalized Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |                                       |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i><br><i>years</i> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>1120</i>  |  |  |  |   |  |   |  |                                       |               |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |                                       |               |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                                       |               |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)                              |  | 21f. LOCATION Street or R.F.D. No City or Town County State   |  |   |  |                                       |               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/19/1968</i> , to <i>14 Dec 1968</i> , that (I) <del>was</del> saw the deceased alive on <i>13 Dec 1968</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <del>did</del> (did not) view the body after death.   |  |  |  |   |  |   |  |                                       |               |  |  |
| 22b. SIGNATURE<br><i>Gordon M. Smith MD</i>  |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>  |               | 22c. DATE SIGNED<br><i>16 Dec 68</i>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Gordon M. Smith, MD</i>   |  | 22e. ADDRESS<br><i>Boyd, Md 20720</i>  |  |   |  |   |  |                                       |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>12-19-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ASH Memorial Cem.</i>  |  | 23d. LOCAT ON (City or Town) (County) (State)<br><i>SANVOY Spring Montg Md.</i>                 |  |                                       |               |  |  |
| 24. FUNERAL DIRECTOR<br><i>Robert L Snowden Rockville Md</i>   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><i>DEC 23 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |                                       |               |  |  |





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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |  |   |   |  |                            |                        |  |
|---|--|--|--------------------------|--|---|---|--|----------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |   |   |  |                            |                        |  |
| CERTIFICATE OF DEATH  |  |  |                          |  |   |   |  |                            |                        |  |
| 18007   |  |  |                          |  |   |   |  |                            |                        |  |
| 18018   |  |  |                          |  |   |   |  |                            |                        |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First Middle Last        |  |   | 2a. DATE OF DEATH                             |  | 2b. HOUR                   |                        |  |
| Norwood Clark Williams  |  |  |                          |  |   | 12 Month 11 Day 68 Year                       |  | 10:40 AM                   |                        |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)               |  | F UNDER 1 YEAR MONTHS DAYS |                        |  |
| Male  |  | Negro  |                          | 11/5/1900  |   | 68 YRS.                                       |  | IF UNDER 24 HRS HOURS MIN  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                            |  |                            |                        |  |
| Washington, D.C.  |  | USA  |                          |  |   | Montgomery Md                                 |  |                            |                        |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)   |   | 12b. KIND OF BUSINESS OR INDUSTRY             |  |                            |                        |  |
| Wheaton   |  | University Nursing Home  |                          | Employee Gov. Print. Off.  |   | U.S. Gov.                                     |  |                            |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  |  |  | 13b. COUNTY              |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET AND NUMBER |  |
| D.C.  |  |  |                          |  | Washington  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                            | 727 Shepherd St., N.W. |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |   |   |  |                            |                        |  |
| First Middle Last   |  |  | First Middle Last        |  |   |   |  |                            |                        |  |
| Alonzo Williams   |  |  | Anna Clark               |  |   |   |  |                            |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT Address   |   |  |                            |                        |  |
| No  |  |  | 579-42-7683              |  |   |   |  |                            |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |                          |  |   |   |  |                            |                        |  |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary and Cerebral metastases</u>   |  |  |                          |  |   |   |  |                            |                        |  |
| 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis primary from</u>  |  |  |                          |  |   |   |  |                            |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>the pancreas.</u>  |  |  |                          |  |   |   |  |                            |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |  |   |   |  |                            |                        |  |
| 1678  |  |  |                          |  |   |   |  |                            |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                            |                        |  |
| APRIL, 1968   |  | CANCER OF PANCREAS   |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |                            |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |   |   |  |                            |                        |  |
|   |  |  |                          |  |   |   |  |                            |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC    |                          | 21f. LOCATION Street or R.F.D. No  |   | City or Town                                  |  | County State               |                        |  |
|   |  |  |                          |  |   |   |  |                            |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>68</u> , to <u>12/11/68</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |   |   |  |                            |                        |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |                          |  |   |   |  |                            |                        |  |
| <u>Pedro I. Matias, M.D.</u>  |  | <u>12/11/68</u>  |                          |  |   |   |  |                            |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |                          |  |   |   |  |                            |                        |  |
| PEDRO I. MATIAS, M.D.   |  | 4712 MONTGOMERY PLACE BELTSVILLE, MD. 20705                                  |                          |  |   |   |  |                            |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State) |  |                            |                        |  |
| Burial  |  | 12/16/1968   |                          | Lincoln  |   | Suitland, Maryland                            |  |                            |                        |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |                          | 12507 REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                    |  |                            |                        |  |
| Mr. Ernest Jarvis Co. 1437 1/2 W. 1st St. N.E.  |  |  |                          | DATE DEC 16 1968   |   | <u>Charles Judge</u>                          |  |                            |                        |  |



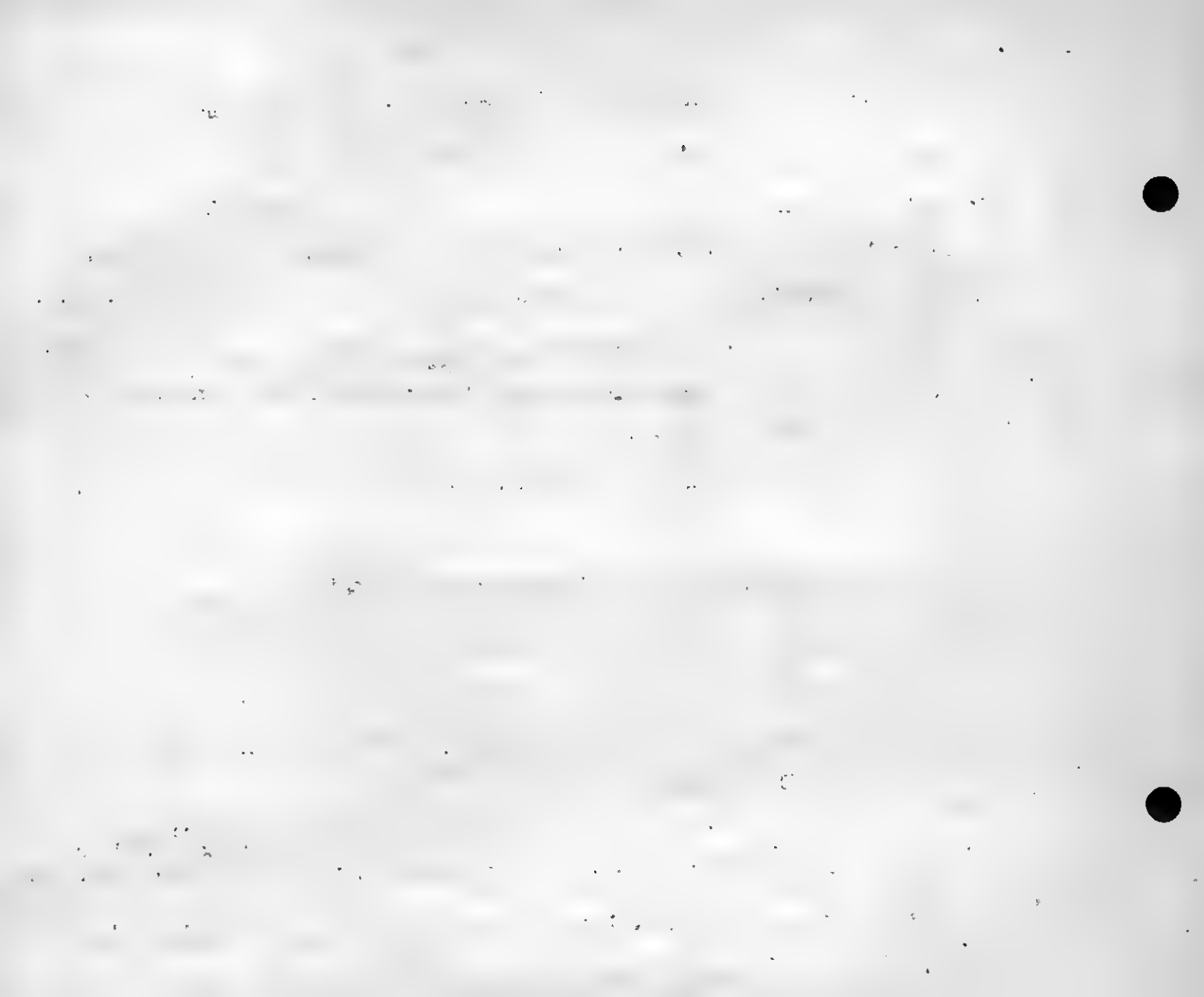
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Henry Valmont Willoughby, III</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>December</b> Day <b>4</b> Year <b>1968</b> |  |  | 2b. HOUR <b>8:15</b> P <b>M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>27 April 1951</b>   |  | 6. AGE (In years last birthday)<br><b>17</b> YRS.                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>District of Columbia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>The Clinical Center, NIH</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Student</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br><b>District of Columbia</b>  |  | 13b. COUNTY<br><b>Washington</b>  |  | 13c. INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>3705 Carpenter St., S.E.</b>                       |  |
| 14. FATHER'S NAME<br><b>Henry V. Willoughby, II</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Clara Fagg</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give year or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>Not available</b>  |  | 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, NIH, Bethesda, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br><b>2040</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Acute Lymphocytic Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>1 month</b> |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Small bowel obstruction, intestinal bleeding, meningitis</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>21 Nov.</b> , 19 <b>68</b> , to <b>4 Dec.</b> , 19 <b>68</b> , that <b>(X)</b> (we) lost the deceased alive on <b>4 December</b> , 19 <b>68</b> and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Richard J. Samaha MD</b> DEGREE  |  |   |  | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                            |  | 22c. DATE SIGNED<br><b>December 5, 1968</b>                                     |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Richard J. Samaha, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>7 Dec 68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bladensburg, Md.</b>        |  |
| 24. FUNERAL DIRECTOR<br><b>Simmons Bros.</b>  |  | ADDRESS<br><b>Wash DC</b>   |  | 25a. RECEIVED BY REGISTRAR<br><b>DEC 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                |  |
| 26. ADDRESS<br><b>Simmons Bros 1661 Good Hope Rd SE</b>   |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18020

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18020

|   |  |  |  |  |                     |  |  |  |  |
|---|--|--|--|--|---------------------|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print)<br><i>Wink Anna</i><br><i>ANNA</i>  |  | First<br><i>ANNA</i>   |  | Middle<br><i>T</i>   | Last<br><i>WINK</i> | 2a. DATE OF DEATH<br>Month <i>Dec</i> Day <i>9</i> Year <i>1968</i>                            |  | 2b. HOUR<br><i>11:15 PM</i>                      |  |
| 3 SEX<br><i>Fe</i>  |  | 4 RACE<br><i>WB</i>  |  | 5. DATE OF BIRTH<br><i>MAY -21, 1917</i>   |                     | 6 AGE (in years last birthday)<br><i>61</i> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>   |  |
| 7a BIRTHPLACE (State or foreign country)<br><i>PA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. COUNTY OF DEATH<br><i>MONTGOMERY</i>  |  | Md.  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Bethesda Md.</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>YOUNG HOME 5721 MONTGOMERY BLVD</i> |  | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Dir of Comput Ctr.</i>   |                     | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>MONTGOMERY</i>   |  | 13c CITY OR TOWN<br><i>BETHESDA</i>  |                     | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>8207 - LILLY ST</i> |  |
| 14 FATHER'S NAME<br>First <i>CLINTON E</i> Middle <i>TAWNEU</i> Last <i>BEAMER</i>  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>ALICE</i> Middle <i>BEAMER</i> Last <i></i>                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <i>NE</i> (If yes give war or dates of service)  |                     | 16b SOCIAL SECURITY NO.<br><i>182 30 2978</i>  |  | 17 INFORMANT<br><i>HOSPITAL RECORDS</i>          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Carcinoma of colon</i><br><i>1538</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 years</i>   |  |  |                     |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i></i>   |  |  |  |  |                     |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                           |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><i>19</i>   |  | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)  |                     |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)  |  | 21f LOCATION Street or R.F.D. No   |                     | City or Town   |  | County State                                     |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>Dec 2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                     |  |  |  |  |
| 22b. SIGNATURE<br><i>Blaine H. Eig</i>  |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYS<br><input checked="" type="checkbox"/>  |                     | MED DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS <input type="checkbox"/>              |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>BLAINE H. EIG</i>  |  | 22e ADDRESS<br><i>9501 George Washington Blvd</i>  |  | 22c DATE SIGNED<br><i>12/9/68</i>  |                     |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b DATE<br><i>12-12-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SALEM E.U.B. TWP</i>  |                     | 23d. LOCATION (City or Town) (County) (State)<br><i>GETTYSBURG ADAMS PA</i>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>ROBERT A. Plumb</i>  |  | ADDRESS<br><i>7557 - WISCONSIN AVE, BETHESDA, MD</i>   |  | 25a RECD BY REGISTRAR<br><i>Charles Judge</i>  |                     | 25b REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  | DATE<br><i>DEC 16 1968</i>                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |   |  |  |  |  |                        |                                    |  |
|---|--|------------------------------|---|--|--|--|--|------------------------|------------------------------------|--|
| 18020   |  |                              |   |  |  | 18021  |  |                        |                                    |  |
| 1. DECEASED NAME (Type or print)  |  |                              |   |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR               |                                    |  |
| First <b>Amy</b> Middle <b>Louise</b> Last <b>WITMAN</b>  |  |                              |   |  |  | Dec Month <b>16</b> Day <b>1968</b>  |  | 12:50A                 |                                    |  |
| 3. SEX  |  | 4. RACE                      |   | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | 7. UNDER 1 YEAR        |                                    |  |
| Female  |  | Caucasian                    |   | Dec 14, 1968   |  | 12   |  | 12                     |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                        |                                    |  |
| Maryland  |  | USA                          |   |  |  | Montgomery   |  |                        |                                    |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give nearest address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |                        | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Bethesda  |  |                              | Naval Hospital  |  |  |  |  |                        |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  |  |                              | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER |                                    |  |
| District of Columbia  |  |                              | Washington,   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  | #8 Neptune Green       |                                    |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |                        |                                    |  |
| First <b>David</b> Middle <b>C.</b> Last <b>WITMAN</b>  |  |                              | First <b>Judith</b> Middle <b>A.</b> Last <b>BURDENS</b>                      |  |  |  |  |                        |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (Unknown)  |  |                              | 16b. SOCIAL SECURITY NO   |  |  | 17. INFORMANT (Mother)   |  |                        | 18. ADDRESS                        |  |
|   |  |                              |   |  |  | Judith A. WITMAN   |  |                        | #8 Neptune Green Washington, D. C. |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |                              |   |  |  |  |  |                        |                                    |  |
| PART I DEATH WAS CAUSED BY:   |  |                              |   |  |  |  |  |                        |                                    |  |
| IMMEDIATE CAUSE (a) <b>Prematurity</b>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 777x DUE TO, OR AS A CONSEQUENCE OF   |  |                              |   |  |  |  |  |                        |                                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                              |   |  |  |  |  |                        |                                    |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |                              |   |  |  |  |  |                        |                                    |  |
| (c)   |  |                              |   |  |  |  |  |                        |                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |   |  |  |  |  |                        |                                    |  |
| 19a. DATE OF OPERATION  |  |                              |   |  |  |  |  |                        |                                    |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                              |   |  |  |  |  |                        |                                    |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                              |   |  |  |  |  |                        |                                    |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                              |   |  |  |  |  |                        |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)  |  |                              |   |  |  |  |  |                        |                                    |  |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |                              |   |  |  |  |  |                        |                                    |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)  |  |                              |   |  |  |  |  |                        |                                    |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)   |  |                              |   |  |  |  |  |                        |                                    |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |                              |   |  |  |  |  |                        |                                    |  |
| 22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>Dec 14</b> , 19 <b>68</b> , to <b>Dec 16</b> , 19 <b>68</b> , that <b>XX</b> (we) lost the deceased alive on <b>Dec 16</b> , 19 <b>68</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>XX</b> (we) (did) <b>NOT</b> view the body after death. |  |                              |   |  |  |  |  |                        |                                    |  |
| 22b. SIGNATURE <b>Gene P. Swartz, M.D.</b> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>   |  |                              |   |  |  |  |  |                        |                                    |  |
| 22c. DATE SIGNED <b>Dec 17, 1968</b>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Gene P. SWARTZ, M.D.</b> 22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>   |  |                              |   |  |  |  |  |                        |                                    |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 23b. DATE <b>12-18-68</b>   |  |                              |   |  |  |  |  |                        |                                    |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>   |  |                              |   |  |  |  |  |                        |                                    |  |
| 23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 24. FUNERAL DIRECTOR <b>W. A. PUMPHREY FUNERAL HOME</b> ADDRESS <b>7557 Wisconsin Ave, Bethesda, Md.</b>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>  |  |                              |   |  |  |  |  |                        |                                    |  |
| 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |  |                              |   |  |  |  |  |                        |                                    |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                       |   |   |   |  |   |  |   |  |
|--|-----------------------|---|---|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                       |   |   |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(Type or Print) <b>GRACE G.</b>   |                       |   | First Middle Last<br><b>WYNHAM</b>                          |   |  | 2a DATE KNOWN OF DEATH<br>Month Day Year<br><b>Dec. 4 19 68</b>     |  | 2b HOUR<br><b>530M</b>                                    |  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>Cauc</b> | 5 DATE OF BIRTH<br><b>31 March 1893</b>   | 6 AGE (In years)<br><b>75</b><br>MONTHS DAYS HOURS MIN.     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS<br>HOURS MIN.                                       |  | 2c DATE PRONOUNCED DEAD<br>Month Day Year<br><b>19 68</b> |  |
| 7a BIRTHPLACE (State or foreign country)<br><b>Australia</b>   |                       | 7b CITIZEN OF WHAT COUNTRY?<br><b>Australia</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 COUNTY OF DEATH<br><b>Montgomery</b>                              |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                       | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b> |   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |   |  |
| 13a USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE <b>District of Columbia</b>   |                       |   | 13c CITY OR TOWN<br><b>Washington</b>                       |   | 3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET AND NUMBER<br><b>4835 Yuma Street</b>                                   |   |  |
| 14 FATHER'S NAME First Middle Last<br><b>White</b>   |                       |   | 15 MOTHER'S MAIDEN NAME First Middle Last<br><b>Roberts</b> |   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                       |   | 16b SOCIAL SECURITY NO                                      |   | 17 INFORMANT <b>Washington, D.C. ADDRESS Mrs. Nereda Sommerville, 4835 Yuma St.</b>        |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Rupture Aortic Aneurysm.</b><br><b>4/29</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Several</b><br><b>years</b> |                       |   |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>add</b>  |                       |   |   |   |  |   |  |   |  |
| 19a DATE OF OPERATION  |                       |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?            |   |  |   | 20 AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                       | 21b TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>                                    |   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |  |   |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                       | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |   | 21f LOCATION Street or R.F.D. No  |  | City or Town  |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                   |                       |   |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>   |                       |   | M.D.  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                     |  | 22b DATE SIGNED <b>Dec. 5, 1968</b>                       |  |
| EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>  |                       |   |   |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                 |  |   |  |
|  |                       |   |   |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>         |  |   |  |
|  |                       |   |   |   |  | ADDRESS (Street, city, town, or county)                             |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                       | 23b DATE<br><b>12/6/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d LOCATION (City or Town) (County) (State)<br><b>Suitland Md.</b> |  |   |  |
| 24 FUNERAL DIRECTOR <b>Taltavull Funeral Home</b>  |                       |   |   | 25a REC'D BY REGISTRAR<br>DATE <b>DEC 9 1968</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV. 1-66

| 18012  |  |                         |  |   |   |   |   |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  |  |                                 |  |  |  |  |
|--|--|-------------------------|--|---|---|---|---|--|--|---|--|--|--|--|---------------------------------|--|--|--|--|
| 18023  |  |                         |  |   |   |   |   |  |  | CERTIFICATE OF DEATH  |  |  |  |  |                                 |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <u>MRS MARY R. YEATMAN</u>   |  |                         |  |   | 2a. DATE-OF DEATH<br>Month <u>December</u> Day <u>16</u> Year <u>1968</u>           |   |   |  |  | 2b. HOUR<br><u>4:30</u> P. M.   |  |  |  |  |                                 |  |  |  |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u> |  | 5. DATE OF BIRTH<br><u>October 26, 1884</u> |   |   | 6. AGE (In years last birthday)<br><u>84</u> YRS. |  |  | IF UNDER 1 YEAR<br>MONTHS <u>0</u> DAYS <u>0</u>                            |  | IF UNDER 24 HRS.<br>HOURS <u>0</u> MIN. <u>0</u>     |  |  |                                 |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>District of Columbia</u>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><u>Montgomery County, Md.</u>  |   |  |  |  |  |                                 |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Bethesda</u>   |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Proctor Lane Nursing Home</u> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Housewife</u>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |  |  |                                 |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)<br><u>Class Maryland</u>   |  |                         | 13b. COUNTY<br><u>Montgomery</u>   |   |   | 13c. CITY OR TOWN<br><u>Kensington</u>  |   |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO      |   |  | 13e. STREET AND NUMBER<br><u>9605 Parkwood Drive</u> |  |  |                                 |  |  |  |  |
| 14. FATHER'S NAME<br>First <u>John</u> Middle <u>Cantwell</u> Last <u>Mary</u>   |  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>First <u>Mary</u> Middle <u>Bigan</u> Last <u>Bigan</u> |   |   |  |  |   |  |  |  |  |                                 |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)  |  |                         |  |   | 16b. SOCIAL SECURITY NO.<br><u>579-60-4950</u>                                      |   |   |  |  | 17. INFORMANT<br><u>Francis X. Yeatman</u>                                  |  |  |  |  | Address<br><u>Bethesda, Md.</u> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4129</u> IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Pulmonary Infarction</u> <u>24 hours</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u> <u>Many years</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Relative Inactivity</u> |  |                         |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sev. hours</u>           |  |  |  |  |                                 |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                 |   |  |  |  |  |                                 |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |  |  |   |  |  |  |  |                                 |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |   |  |  |  |  |                                 |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1963</u> , to <u>Dec 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 16, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                         |  |   |   |   |   |  |  |   |  |  |  |  |                                 |  |  |  |  |
| 22b. SIGNATURE<br><u>George H. Mitchell</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |                         |  |   |   |   |   |  |  | 22c. DATE SIGNED<br><u>Dec 16, 1968</u>                                     |  |  |  |  |                                 |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>GEORGE H. MITCHELL</u>  |  |                         |  |   | 22e. ADDRESS<br><u>11125 Rockville Pike</u><br><u>Rockville, Maryland</u>           |   |   |  |  |   |  |  |  |  |                                 |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                         | 23b. DATE<br><u>12-20-68</u>   |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Suitland Prince George</u> <u>Inde</u> <u>Md</u> |   |  |  |  |  |                                 |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Robert A. Pumphrey</u><br><u>7557-Wisconsin Ave., Bethesda, Md.</u>   |  |                         |  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 26 1968</u>                                       |   |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                          |  |  |  |  |                                 |  |  |  |  |

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18013

CERTIFICATE OF DEATH

18024

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LIONEL JUSTUS ZIERDT</b>   |  |  | 2a. DATE OF DEATH<br>12 Month 6 Day 68 Year                         |   |  | 2b. HOUR<br>9:30 AM  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>JUNE 12, 1900</b>  |  | 6. AGE (In years<br>last birthday)<br>68 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                         |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>PENNA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. AMERICA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>KENSINGTON</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>3001 JENNINGS ROAD</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>MECHANIC FOREMAN</b>                                       |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>TRUCKING</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |   | 13c. CITY OR TOWN<br><b>KENSINGTON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET AND NUMBER<br><b>3001 JENNINGS ROAD</b>              |  |
| 14. FATHER'S NAME First Middle Last<br><b>JUSTUS ZIERDT</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>AMANDA KLINGER</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>YES</b>   |  | (If yes give war or dates of service)<br><b>6/14/19-1/12/22</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>578-12-7913</b>  |  | 17. INFORMANT<br><b>MARIE E. ZIEDT</b><br>Address<br><b>3001 JENNINGS ROAD<br/>KENSINGTON, MD.</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG (PRESUMPTIVE)</b><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. 163X (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 YEAR</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC OBSTRUCTIVE EMPHYSEMA, ARTERIOSCLEROTIC HEART DISEASE</b>   |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work of work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1966, to 12/6, 1968, that (I) (we) last<br>saw the deceased alive on 12/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Richard H. Pollen MD</b>   |  | DEGREE   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>12-6-68</b>   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>RICHARD H. POLLEN MD</b>   |  | 22e. ADDRESS<br><b>10400 CONNECTICUT AV, KENSINGTON, MD</b>  |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>DEC 9, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARK LAWN CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ROCKVILLE MONTGOMERY MD.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS CO.</b>  |  | ADDRESS<br><b>8655 GEORGIA AVE.<br/>SILVER SPRING, MD.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 11 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |



*[The following text is extremely faint and illegible, appearing to be a series of lines of handwriting or a typed document.]*